



PHD

**The Contribution of Universal Health Insurance Coverage Scheme  
to villagers' wellbeing in Northeast Thaila**

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**The Contribution of Universal Health Insurance Coverage Scheme  
to villagers' wellbeing in Northeast Thailand**

Submitted by

**Farung Mee-Udon**

**For the Degree of Doctor of Philosophy  
of the University of Bath**

**June 2009**

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## Dedication

*For villagers*

*who play a vital role in this thesis but they remain anonymous.*

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## Glossary

The definitions offered here are mainly applicable only to this present work. In this thesis as Thai is the mostly used. The origin of the other languages will be put in brackets.

Arokayasom ( Pali): A place without disease

Baan: A village in Thai

Baht: A Thai currency. 1 Baht is composed of 100 satang.

Broo or Ka: one of the ethnic groups living in the northeast of Thailand

Can: a traditional musical instrument made of bamboo, famously used in the north-eastern part of Thailand

Dukkha (Pali): The unsatisfactory; un-fulfilling; suffering; discontent

GorKorKorjor project: Krong Gan Kae Panha Khwarm Yakjon

Heet-Sib-Song Kong-Sib-See: Village rules and the religious ceremonies in the northeast that villagers should perform every month.

Isaan: The Northeast of Thailand

Ka Lam (Isaan language): Taboos

Khon Jon: Poor people

Kin Dee Yuu Dee: wellbeing

Khwarm Pha Sook: wellbeing

Khwarm Mai Mee Rok Pen Lap An Prasert: Absence of disease is precious good fortune

Khwarm Kreng Jai: It is a noun form of Kreng Jai; see Kreng Jai

Khwarm Kreng Jai pen Som Bat Khong Pu dee: Khwarm Kreng Jai is a treasure which belongs to well mannered people

Kreng Jai: To be afraid of offending (one), to be considerate of another's feeling

Krong Kan Sor Por Row: Free Medical Welfare Scheme for People with Low Incomes and Those That Society Should Help (MWS)

Luk Phuchai: Being real man; manhood

Luk Phuying: Being real women; womanhood

Mattannuta (Pali): Knowing moderation.

Mot luuk: womb; uterus

Pali: The ancient Indian language in which the Buddhist suttas or discourse were written down.

Patjai Sii: the four necessities of life: clothing, food, dwelling and medicine.

Pen Nii Boon Koon: to be under an obligation. This term is often used with the word ‘katannu kataveti’, which is Pali for gratitude. Gratitude is considered by Thais as a highly valued character trait.

Phook Siew: An Isaan ceremony for friends to become close friends, usually they are in the same age and same gender. In the ceremony, friends will be tied their hand with the white strings by the elderly. The elderly will give them blessing for their good relationship and spirit. The white strings are used as symbol to tighten friendship.

Phuthai: one of the ethnic groups living in the northeast of Thailand

Por Jai: Contentment; satisfaction

Pra Ajarn: Venerable monk

Roo Suek Dee Khuen: Feeling better

Sak-di-na: A traditional Thai system of class division

Sam Liam Ka Yeon Phu Kao: A triangle that moves The Mountain, a concept initiated by Dr. Pravet Wasi in 2000. This approach is considered by healthcare administrator as an important innovation for Thai healthcare reform.

Sookhaparb: Health

Sookaparb dee mee kha gwa nguen thong: health is better than money

Sookka Pava: Being well (in health); wellbeing

So: one of the ethnic groups living in the northeast of Thailand

Sahapan Chao Na Chao Rai: The Peasant's Federation

Samatcha Khon Jon: Assembly of the Poor

Songkran : Thai New Year

Nutti Tanhah Sma Natee (Pali): No river is equivalent to the river of desire.

Patjai Sii: The four conditions/necessities of life: clothing, food, dwelling and medicine.

Siew (Isaan language): Close friend

Sabai Jai: Pleasure

Tam Boon: Usually refers to Thai Buddhist ceremony whereby one receives merit by offering food to monks

Tanha (Pali): craving. This is the main cause of Dukkha

Thai-Lao: the biggest ethnic group living in the northeast of Thailand

Thaksin Pen Devada Ma Prod: Thaksin is an angel who came to help the people.

Yor: one of the ethnic groups living in the northeast of Thailand

Yu Dee Mee Hang (Isaan language): A well-known blessing in Isaan.

It means 'May you live well, having energy'

Yuu Dee Mee Sook: wellbeing

Yuu Yen Pen Sook: wellbeing

Yuu Fai: A tradition practised by women after having childbirth. It involves staying near a fire for days in order to help the womb dry and clean itself.

Wat : temple

Wat Baan: Home temple

Wat Pa: Forest temple

## Acronyms

ABAC poll	The poll conducted by Research Centre of Assumption University
AIDs	Acquired Immune Deficiency Syndrome
AFP	Agence France Presse
CAQDAS	Computer-assisted qualitative data analysis software
CAM	Complementary and Alternative Medicine
CBA	Cost-Benefit Analysis
CCF	Christian Children's Fund
CEA	Cost Effective Analysis
CIS	Clinical Information Systems
CSMBs	The Civil Servants Medical Benefit Scheme
CUA	Cost-Utility Analysis
CUPs	Contracting Units of Primary Cares
DTAM	Department for Development of Thai Traditional and Alternative Medicine
ESRC	The UK's Economic and Social Research Council
EU	European Union
GNP	Gross National Product
GDP	Gross Domestic Product
GPs	General Practitioners
HA	The Hospital Accreditation system
HIV	Human Immuno-deficiency Virus
HRQoL	The Health-Related Quality of life Approach
HSRI	Health System Research Institute
HSRO	[The National] Health Systems Research Office
ICD	International Statistical Classification of Disease and Related Conditions
IHPP	The International Health Policy
IMF	The International Monetary Fund
IPSR	The Institute for Population and Social Research
MoPH	The Ministry of Public Health
MRC	The UK Medical Research Council
MWS	Free Medical Welfare Scheme for People with Low Incomes and Those That Society Should Help
NCCAM	National Centre for Complementary and Alternative Medicine
NESDB	The National Economic and Social Development Board
NGOs	The Non-Governmental Organisations
NHA	National Health Act
NHS	The National Health System (United Kingdom)
NHSO	The National Health Security Office
NHI	National Health Insurance
NHP	The Nottingham Health Profile
PCUs	Primary Care Units
PLWHA	People Living With HIV and AIDS
PMS	Performance Management System
PPDO	The Public Policy Development Office
PPP	People's Power Party
RANQ	The WeD's Resource And Needs Questionnaires
RCT	Randomised Controlled Trial
RPA	The Resource Profiles Approach

RRT	Renal Replacement Therapy
SF-36	The short-form health survey with 36 questions
SHI	Social Health Insurance
SSS	The Social Security Scheme
SIP	Social Investment Project
TAO	Tambon Administrative Organisation
TDRI	The Thailand Development Research institute
THN	The Theory of Human Need
TNSO	The National Statistical Office Of Thailand
TRT	Thai Rak Thai party
UC	Universal Health Insurance Coverage
UNCC	The United Nations Conference Centre (Thailand)
UNDP	United Nation Development Programme
UNICEF	The United Nations Children's Fund
WeD	Wellbeing in Developing Countries project
WeDQoL	The WeD-Quality of Life approach
WFE	Wellbeing Focused Evaluation
WHO	World Health Organisation
WSR	Whole Systems Research

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My oldest sister, who decided not to go to university because she knew that our family could not afford it if we all studied. Her sacrifice gave me a chance to further my study.

This thesis is about healthcare and wellbeing. If anything is inaccurate, I ask the reader to enlighten me and please give some constructive comments. As for whatever maybe accurate, I hope the reader will make the best use of it in your professional life, so as to help to improve healthcare for the wellbeing of people.

Finally, I would like to share ‘a moment of wellbeing’ with you whoever has come across this thesis with a part of a Buddhist chant on reflections on universal wellbeing as follows:

*Now let us chant the reflections on universal wellbeing*

*May I abide in wellbeing, in freedom from affliction, in freedom from hostility, in freedom from ill-will, in freedom from anxiety, and may I maintain wellbeing in myself.*

*May everyone abide in wellbeing, in freedom from hostility, in freedom from ill-will, in freedom from anxiety, and may they maintain wellbeing in themselves.*

*May all being be released from all suffering,  
And may they not be parted from the good fortune they have attained.*

The researcher



## Abstract

The Universal Healthcare Insurance Coverage Scheme (UC) in Thailand, also known as the 30 baht scheme, was introduced in 2001 to improve access to healthcare among uninsured people before the UC scheme started. The ultimate goal of the UC scheme is to promote the wellbeing of Thai people. This thesis proposes a new approach to evaluation, 'Wellbeing Focused Evaluation (WFE)', to understand the impact of the UC scheme on the wellbeing of villagers in Northeast Thailand. This approach is adapted from the 'Wellbeing in Developing Countries' conceptual models, as proposed by Gough and McGregor (2007). The WFE is used to understand villagers' experiences of having and using the UC card. Additionally, it investigates the villagers' satisfaction with having and using the UC card and explores how this satisfaction contributes to their satisfaction with life. An ethnographic research was conducted for eight months in one non-remote and one remote village using a multi- methods approach, including questionnaire surveys, focus groups, in-depth interviews, participant observation and some of the WeD's methods. The WFE shows that for villagers' understanding of 'wellbeing', good mental and physical health are particularly what they need for 'living well'. Most villagers consider wellbeing as a matter of having good mental and physical health more than as possessing wealth. In this respect the fact that before the UC scheme was introduced, the poor had very limited access to healthcare. By investigating the villagers' experiences, it was found that the UC scheme has provided a sense of security and has lowered the cost of healthcare, thereby contributing to the wellbeing of the villagers. In particular it has benefited the poor in both of the studied locations, as indicated by the highest rate of UC card usage. However, the study also found that not everyone with a UC card used it and the main reasons given for this were: trivial illness, opportunity cost, having alternative facilities, the poor quality of service on offer and gender culture in the villages. In addition, the UC continues to experience problems with regards to its implementation and has come in for criticism. Such criticism has included: restricted number of choices, low quality of service and discriminatory treatment. Certain villagers feel they have been discriminated when using the UC because of their low economic level in particular when comparing to the other economic classes and to other two healthcare schemes provided by the government to the rest of Thai population. Although these problems have affected the UC card usage by villagers, they have not adversely affected their wellbeing and having a UC card is viewed by the villagers as a form of life insurance, which they can use whenever they need to. Therefore even those who have never used the UC card, the UC scheme still has promoted better feeling of security thereby minimising one threat to the wellbeing of villagers. The UC has not only enhanced people's wellbeing individually but also collectively as one person's wellbeing is not entirely independent from the other. Rather, they are indeed closely related. In this way, the UC scheme has created better conditions for better societies for most of Thai citizens in pursuit of their wellbeing. Recently, wellbeing becomes one of the desired outcomes of the Thai government policy and of the health policy. In order to apply this concept into the UC evaluations, it is argued that the 'WFE' can be applied as an analytical as well as explanatory approach in addition to some extents to the conventional UC evaluations UC evaluation. The WFE is particularly appropriate for a study of rural villages, in both non-remote and remote areas, in Thailand that are highly contextualised. The framework may also be applied to other forms of social policy, or in other developing countries particularly concerning the impact of its policy on people's wellbeing.

***‘Health is the highest gain  
Contentment is the greatest wealth’***

*Saying of the Buddha (Narada 1993:204)*

# Chapter 1: Introduction

*The Universal Health Insurance Coverage (UC) scheme, a new medical programme for Thailand, launched in 2001, was described by the editors of the Bangkok Post as ‘the most ambitious universal healthcare system ever attempted anywhere in the world’ (Swartzentruber 2001).*

The aim of this thesis is to develop a new approach to evaluation, ‘Wellbeing Focused Evaluation (WFE)’, to understand the impact of the UC scheme on the wellbeing of villagers in Northeast Thailand. The approach builds on and extends the conceptual and methodological insights of an international research programme into wellbeing in developing countries<sup>1</sup> (Gough and McGregor, 2007).

## 1.1 Rationale: Why ‘Wellbeing Focused Evaluation (WFE)’?

The justification for applying WFE to healthcare evaluation in Thailand can be attributed to two key factors. The first concerns the current economic, political and social transformation that has been taking place in Thailand. Such changes have led to the Thai population broadening its aspirations from having economic security to having wellbeing as the main development goal, as set out in the 7<sup>th</sup> National Economic and Social Development Plan (1992-1996) and laid out in the 8<sup>th</sup> plan (1997-2001) of the office of the National Economic and Social Development Board (NESDB 1997). The core concept in the 8<sup>th</sup> plan was considered an important turning point in the country’s development planning, as it adjusted to the development paradigm that placed people at the centre, subsequent to the economic crisis in 1997. During that period, health issues were given priority in order to improve people’s wellbeing. This was similar to the aim of the 9th development plan (2002-2006) that adopted the King’s principle of the ‘sufficiency economy’. The wellbeing concept was carried over from the 8<sup>th</sup> plan that had put considerable emphasis on solving the problems that had been brought about by

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<sup>1</sup> Wellbeing in Developing Countries (WeD) is a project that aims to develop a conceptual and methodological framework for understanding the social and cultural aspects of wellbeing in developing countries. It is an ESRC funded research programme at the University of Bath. Current research work has been on poverty, inequality and wellbeing in specific societies in: Bangladesh, Ethiopia, Peru and Thailand ( <http://www.welldev.org.uk> )

the economic crisis. The ultimate goal was to achieve sustainable development and wellbeing through balanced development in various aspects of life including quality of life, society and the environment. The importance of wellbeing has been emphasised in the nation development plan as illustrated below:

‘The Ninth Plan (2002-2006) adopted the Sufficiency Economy philosophy to guide the development and administration of the country, at the same time as continuing the holistic approach to people-centered development from the Eighth Plan. The plan prioritised solutions to problems arising from the economic crisis in order to build an economy with strong internal foundations and resilience to external changes, while aiming for balanced development with respect to people, society, economy, and environment in order to achieve sustainable development and the well-being of the Thai people’

(NESDB, 2009)

Increasing focus on the concept of wellbeing and attempts to incorporate it into the public developmental framework have also emanated from the Public Policy Development Office (PPDO 2007). In 2007, the PPDO organised an international conference to discuss this concept at the United Nations Conference Centre (UNCC) in Bangkok, at which many participants suggested that the notion of wellbeing should combine both objective and subjective dimensions, because both of these factors impact on human beings and thus it is important to take them into account for effective policy development (McGregor *et al.*, 2008; Cummins, 2008; Frijters and Mujcic, 2008; Gray *et al.*, 2008).

The second factor which supports the use of WFE relates to the reforms which have been taking place within the Thai health sector for more than two decades, in response to the increasing demand for better healthcare policy, i.e. one that is affordable and equitable, as set out for the first time in sections 52 and 82 of the 1997 constitution of the Kingdom of Thailand (Pannarunothai, 2000, 2005; Wongkongkathep *et al.*, 2004).

An event that triggered significant change took place in 2001 when a new health scheme called the Universal Health Insurance Coverage scheme (UC) was created, supported by a group of academics, public health administrators, civil societies and politicians. The

major concern regarding the direction of public health was that it should provide the people with an adequate health service and quality of life, prescribed in the 1997 Constitution as:

‘All Thai people have an equal right to receive standard public health services, and the indigent shall have the right to receive free medical treatment from public health facilities of the state, as provided by the law.’

(Section 52 of the 1997 Constitution)

Socio-economic improvements combined with increasing interest in wellbeing at the national level and in the Thai health sector itself have led the government to focus more on public health policy. Amid all the changes that have been taking place in the Thai health system, the concept of wellbeing has become an important feature of policy goals in health promotion and healthcare. More recently, the growth of interest in wellbeing can be seen through the first national health assembly conference in Bangkok, which placed wellbeing as a primary national development goal (see Box 1).

Box 1. 'Wellbeing' becomes the Thai national goal

Dr Pravet points out using 'wellbeing' as the nation's goal

Today (11 December 2008) at the United Nations [Bangkok]. Dr. Pravet Wasi<sup>2</sup>, , a senior citizen, gave a speech on 'Thai people have the biggest dream in the world' in the first national health assembly. The Thai dream is that everyone has wellbeing in complete dimensions: physical, mental, social and wisdom. This must be dependent on the development of each dimension taking place at the same time. Wellbeing must be a goal for the nation and the world. In order to drive the goal, it needs participation from all civil societies in using wellbeing rather than GDP [Gross Domestic Product] as an indicator. This is because using only GDP may actually create social problems and lead the world into crisis. Now the world is very sick, in particular through the economic crisis.

The senior citizen further states that propelling wellbeing is difficult. Thai society has complex problems; thus it is difficult to do things. It cannot be done by governmental power only. Solving the problems requires the participation of all citizens.

'In this world, there are many international organisations that are driving towards the concept of wellbeing but they have not been successful because the tools which are used in the political and bureaucratic system are incapable. Thus one needs to have shared knowledge in order to propel it', Dr. Pravet said.

Translated from Thai to English by the researcher  
(Matichon newspaper cited in National Health Commission Office -NHCO, 2009)

Since Thailand is undergoing rapid change, it is important to use an approach that can be used to analyse this transformation and explore the wellbeing implications of this change. However, although the ultimate objective of the UC scheme is to enhance the wellbeing of the Thai people, its evaluation, which is used by the National Health Security Office (NHSO), i.e. ABAC public opinion polls (conducted by the Research Centre of Assumption University), does not take into consideration the fact that the healthcare system and Thailand as a whole are constantly undergoing change. With the intention of addressing these shortcomings, it is proposed that a WFE is used to enable a broader and more effective means to evaluate healthcare (see Chapter 3).

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<sup>2</sup> Dr. Pravet Wasi has been a major figure in Thai development debates and particularly in the Thai health sector and the development of the UC scheme (see Chapters 2 and 3). The term senior citizen may have a different meaning in Thai culture than in other societies. Respect for seniority, experience and knowledge is an essential value of the Thai culture, which is itself influenced by Theravada Buddhism (The Teaching of Elders) which still thrives in Sri Lanka, Myanmar and Thailand (see Chapter 3).

## 1.2 Introduction to 'Wellbeing Focused Evaluation (WFE)'

According to the WeD project, wellbeing is defined as 'a state of being with others, where human needs are met, where one can act meaningfully to pursue one's goals, and where one enjoys a satisfactory quality of life' (Gough and McGregor, 2007). From this definition, it becomes evident that wellbeing encompasses people's objective circumstances and subjective perception of their condition. In addition, it involves relationships with others, so the wellbeing of one person is related to that of others. The significance of the conditions and wider contexts that link the wellbeing of individuals to that of the social structure and organisations is also emphasised by McGregor:

'...wellbeing is a social state which we experience in society through our relationships through others ...good development is the creation of the conditions in societies around the world in which all people can reasonably conceive of , pursue and expect to achieve their wellbeing'(2008:2).

McGregor argues that not only does this highlight the importance of considering the impact of 'conditions' on a person's wellbeing, but it also illustrates the relationship between people and society in two important ways.

Firstly, 'government does not deliver wellbeing; men, women and children achieve this through their relationships with others in society. But government plays an essential role in ensuring that the conditions are in place within which people might reasonably expect to achieve it' (McGregor, 2008:2).

Secondly, as there is enormous variation between societies and their stages of development, the government should consider making choices based on evidence from specific societies, which indicates the different roles that the state, the economy and civil society might play in putting in place the conditions for wellbeing for people with different identities (i.e. men, women and children) and capabilities (i.e. people with different resources and power) (McGregor, 2008).

Similarly, Phillips and Berman (2003) suggest that in order to improve people's wellbeing, 'social quality' needs to be considered, which includes elements of

socioeconomic security, social inclusion, social cohesion and empowerment. These constitute the conditions by which people can achieve both individual and collective wellbeing (Phillips and Berman 2003).

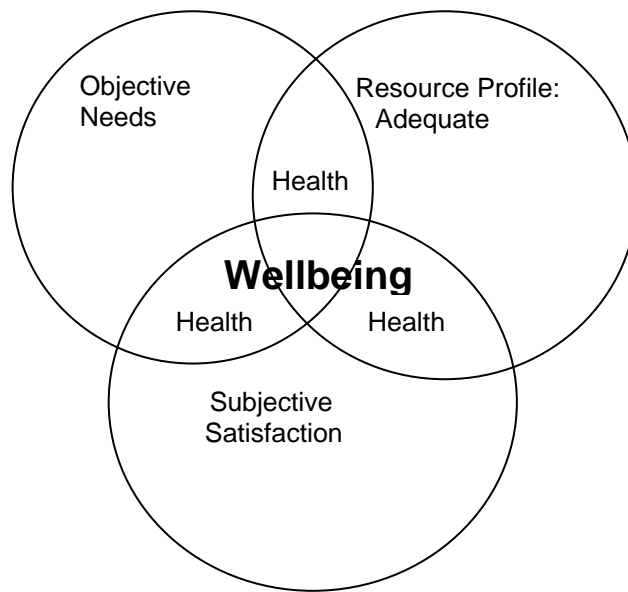
Gough and McGregor (2007) further argue that wellbeing is not only an outcome, but a ‘condition of being’ that arises from the dynamic interplay of outcomes and processes. Lastly, the interplay between outcomes and processes is firmly located in society and is shaped by: social, economic, political, cultural and psychological processes.

The importance of health can be explained by the three main theoretical approaches that have been employed to underpin the WeD’s framework, that is: the Theory of Human Need (THN) (Doyal and Gough, 1991), the Resource Profiles Approach (RPA) (Lewis *et al.*, 1991; Lewis and McGregor, 1992) and the WeD Quality of Life approach (WeDQoL, 2006). Firstly, according to the THN, whilst health is considered to be a basic human need, appropriate healthcare service is categorised as one of the intermediate needs of human beings. The objectives of health policies are to satisfy basic needs and access to appropriate healthcare is regarded as an important factor for meeting people’s needs. Secondly, the RPA classifies the types of resources that people are able to command in the pursuit of their wellbeing. These resources are: material, human, social, cultural, and natural. In this approach, good health is a human resource, which contributes to the achievement of wellbeing, as well as being an element of wellbeing itself. In light of this breakdown, it becomes difficult to conclude that individuals will experience well/ill being solely through one resource. That is, they may have access to other resources in order to maintain their wellbeing, if one particular resource is lacking. Thirdly, the WeDQoL approach looks at subjective aspects of health. It measures how satisfied people are with what they have, and what they can do and be, as well as what they think and feel about what they have and do, according to their self-evaluation (Camfield, 2004).

In summary, health lies at the intersections between objective needs, resources and subjective satisfaction. Moreover, wellbeing is situated at the centre of the health components, as shown in Figure 1.1.



Figure 1.1 A view of WeD's approach in relation to health and wellbeing



Source: The researcher's own diagram

This figure highlights the fact that the WeD approach combines the objective needs of wellbeing, e.g. health and material circumstances, such as income and expenditure, the subjective dimensions, such as people's own appraisals of their levels of satisfaction with their lives, and the relationships of people with the resources that they can use to enhance their wellbeing, in the context of the culture in which they live and the values they adopt.

Similar to the WeD approach, a Wellbeing Focused Evaluation (WFE) can employ both objective and subjective measures and allows for more emphasis being put on subjective views and assessments of wellbeing. A WFE is used here to assess the perceived wellbeing of villagers in the context of the UC scheme in Thailand. The research that has been carried out focused on villagers' actual experiences of, access to and use of the scheme, by looking at whether people of different genders, ages and classes in two villages, one remote and one non-remote, have had different access to and use of the UC scheme, and if so, how this has affected their wellbeing.

A WFE approach follows the trend towards including subjective measures in healthcare evaluation, such as in the SF-36<sup>3</sup> which has been used widely by health psychologists

<sup>3</sup> The SF-36 is a multi-purpose, short-form health survey with only 36 questions. It yields an 8-scale profile of functional health and wellbeing scores as well as psychometrically based physical and mental health summary measures and a preference-based health utility index (Ware, 2007).

and economists in economically developed countries (Stewart and Ware, 1992). However, conventional healthcare evaluation approaches have been criticised for lacking views from other disciplines. For example, epidemiology and health economics have dominated research in investigating public health, whereas evidence from other social science disciplines, such as sociology, anthropology, social epidemiology, medical geography, health psychology and political sciences, has made only modest contributions to assessments of healthcare (The Institute of Development Studies-IDS, 2005). This is also true in Thailand, where the evaluation concepts and methodologies described above have dominated and most evaluators are from a health science background. This thesis addresses the criticism above by proposing a different angle of healthcare evaluation using social science disciplines which focus on the dimensions of wellbeing.

Although the WFE is an approach which is based on the WeD framework, it has been adapted, applied and developed further by the researcher to be used as a practical tool in the assessment of health policy interventions, in this case the Universal Healthcare scheme. WFE is wellbeing focused. That is, it recognises that healthcare interventions must be measured against a defined set of criteria which include its effect on the objective, subjective and relational dimensions of people's lives, in this case rural people who have experienced the UC scheme in Thailand. By undertaking a more holistic form of healthcare evaluation than previous evaluations of the UC scheme, it is hoped that tangible evidence will be produced about how villagers use the UC scheme to meet their needs, increase their resources, and achieve good quality of life (see Chapters 6 and 7).

In order to use WFE to evaluate the UC scheme, an ethnographically oriented multi-method approach was developed which incorporated questionnaire surveys, in-depth interviews, focus groups and participant observation. The development of each tool was informed by a wellbeing perspective which meant that they were designed to increase understanding of how villagers access and use the UC scheme to meet their needs, and how the UC scheme enables them to act meaningfully to achieve their goals and increase their satisfaction with life. For example, administration of the Person Generated Index (PGI) in the questionnaire (see pxx for a description of this measure),

followed by an in-depth interview enabled understanding of whether villagers perceived that the UC scheme responded to their needs.

The research sought to implement the integrated tools of the WFE for different purposes and in different contexts. The tools used in this research include:

(a) Questionnaire surveys to interview villagers in order to gain a general view about their wellbeing. Example of the questions are as follows:

- Can you please tell me that the word ‘wellbeing’ means to you?
- In general what are the indicators of people’s wellbeing?
- Please tell me about your wellbeing at the moment?

Additionally, in order to obtain particular points on health and healthcare access, the following questions were asked:

- Have you used a gold card ?(when sick)
- Have you ever used a gold card? (since you have had the card)

(b) In-depth interviews were used to gain more detailed information on people’s perspectives which could not be captured by the questionnaire tool as the questions were structured and focused on the objective dimensions of people’s lives. They were also used to reduce the sense of objectification felt by the interviewee as villagers could take much greater control of the process in terms of having more freedom to express their experiences and their feelings about the UC scheme. The semi- structured interview guideline included questions such as:

- What are your actual experiences of using the gold card?
- What have you found good and bad about using it?
- When comparing the old card and the new card which one are you most satisfied with? Why?
- What would you like to change the most when using the gold card?

Two different types of focus-group discussions were used to draw out further information on i) how villagers see wellbeing, health and healthcare and how they access healthcare and the UC scheme in particular, and ii) gender and health. There was a lively discussion between the participants which helped people develop their ideas and acted as a form of triangulation as statements could be challenged by others in the group. As the first topic was addressed with Village Health Volunteers, the researcher used mixed groups of men and women. However, for the second topic (‘gender and health’) separate groups were conducted for male and female villagers.

To ensure that villagers felt able to respond freely these focus groups were conducted by a researcher of the same gender as the participants.

Examples of questions for the first focus group include:

- What are your conceptions of wellbeing/ good life/ better life? Why do you think in this way?
- Are there different conceptions of wellbeing between women and men? Why do you think in this way?
- Are you able to access the 30 baht healthcare project?  
If so, what are your actual experiences of accessing the project?  
If not, what are the problems?

Examples of questions for the second focus group include:

- What is your first thought if we talk about Women?
- What is your first thought if we talk about Men?
- How did you teach your children to be a woman?
- How did you teach your children to be a man?
- How did you define the meaning of healthy people by age and gender?
- In your opinion, what are the differences between female and males in terms of illness?

(c) Participant observation was used to enable the researcher to better understand villagers' lives. The researcher not only observed individual episodes of using and thinking about the UC scheme, but was able to situate these episodes within people's daily lives and in the wider and interrelated context of their community and society. In addition, this tool was also useful in the process of triangulation where, for example, people's behaviour did not match their responses to the survey.

Further information about the different tools is provided on pages 143-151 and in Appendices 2, 3-1, 3-2, 4 and 5.

In summary, the WFE extended the WeD approach and tailored it to deal with a specific context, that is health and healthcare in rural Thailand. While WeD covered many aspects of people's lives, including their health, WFE focuses specifically on healthcare

and how this can be evaluated. In so doing it operationalises the objective, subjective and relational dimensions that are emphasised in WeD in a specific context. The lessons learnt through this process have supported the development of an approach that can be replicated in evaluations of other interventions, for example, to improve school quality. The WFE approach will be discussed in further detail in Chapter 3.

### **1.3 The problem: What has happened in Thailand with regards to the UC scheme?**

The UC scheme is known in Thai as the ‘30-Baht<sup>4</sup> scheme’ and, as Thailand has been among the first of the lower-middle-income countries to have introduced universal healthcare coverage for its population, it has wider implications for health policy in developing countries. The rapid coverage expansion and primary care financing reforms have been seen as an innovative and attractive model for other middle-income countries (Hughes and Leethongdee, 2007) and the World Health Organisation (WHO) has indicated that its success will be watched closely as a possible model for other countries (Towse, 2003; MoPH, 2004).

In Thailand, inequality and inefficiency in the distribution of healthcare services has been a major issue for those who use the healthcare system (Towse *et al.*, 2004; Pannarunothai and Mills, 1997; Pannarunothai *et al.*, 2004; National Health Security Office (hereafter the NHSO), 2002). Although the government had attempted to provide various health insurance schemes before 2001, these systems had proved problematic and were often criticised. The main criticisms included: the burden of high expenditure for healthcare and the inequalities of access to the available healthcare systems, that is to say the poor could not afford a similar quality to that of the rich and only some Thais were protected. Moreover, it was reported in 2001 that around 30 % of Thai people had no health insurance and thus had to pay for treatment (Tangcharoensathien, 1996; Jirojjanakul *et al.*, 2004; Suraratdecha *et al.*, 2005).

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<sup>4</sup> The term is well-known because it was originally the maximum fee required from a patient for a consultation (30 baht is approximately £0.50, \$0.86). Under the scheme, there were two types of card. The first was a free card and the second a co-payment card, with which people paid 30 baht for each visit or admission. Although all cards launched under the UC scheme were replaced by free medical treatment throughout the country from 31 October 2006, the term ‘30 baht scheme’ continues to be the common parlance because it was used in a previous ruling party’s political campaign under the motto ‘30 baht treats all diseases’ to explain that all illnesses could be treated for only 30 baht (see Chapter 2).

These problems led to changes regarding the organisation and financing of the healthcare system, so as to improve the situation. These changes were driven by governmental initiatives and advocates for civil society, such as: research institutions, Non-Governmental Organisations (NGOs), user groups and private sector representatives. Consequently, various policies were introduced, particularly aimed at increasing access to healthcare. This culminated in the UC scheme, which was launched in 2001 and driven forcefully by the former Prime Minister Thaksin. It was very popular and contributed greatly to his electoral success, certainly amongst the poor. However, this led to the UC scheme being criticised for its populist nature, and some scholars have argued that it was a tactic to get votes from the poor (Siamwalla, 2003; Phongpaichit and Baker, 2004, 2005; Warr, 2005).

The implementation of the UC scheme began in April 2001 and was subsequently expanded across the whole country in October of the same year. It was the most expansive single policy initiative, in terms of coverage of the population, and had the largest budget of all the major initiatives introduced in 2001 (Changsorn and Chaitrong, 2003). Its aim is to decrease inequity in healthcare by providing the same quality of service to uninsured people as to those covered by other forms of the governmental insurance, such as the Social Security Scheme (SSS) and the Civil Servants Medical Benefit Scheme (CSMBS).

Since the UC scheme started, debates regarding its impact and effectiveness have emerged and two perspectives in these debates have come to the fore. On the one hand, supporters arguing in favour of the UC scheme hold the viewpoint that it has improved access among uninsured people, by lowering costs. In support of this view, government public opinion polls used to measure the success of the scheme have repeatedly shown that since 2001 approximately 80- 90 % of Thai people have expressed themselves to be satisfied with its provision. On the other hand, opponents argue that the UC scheme has created numerous problems, many of which have been reported in newspaper articles and research studies. These problems have included staff shortages caused by numerous resignations of doctors, a corresponding increase in workload among the remaining healthcare workers, and inequitable treatment of patients. In addition, it has been contended that the quality of the UC scheme, as a whole, has been affected by ambiguity and instability within its administration. Although several research studies have been undertaken to investigate this controversy, the government continues to rely

on its high level of support in the public opinion polls to justify its view that people have high levels of satisfaction with the scheme. They have taken the view that such large-scale general surveys are an acceptable way of measuring public satisfaction with the UC scheme and promotion of the results of these polls has served them well in terms of their popularity. With regard to the debate outlined above, this thesis aims to contribute to it by proposing and undertaking an alternative approach to evaluating the UC scheme, that of a ‘Wellbeing Focused Evaluation (WFE)’. In this context, this researcher posits that to gain a more comprehensive understanding of the impact of the UC scheme on the Thai people, a more holistic study is needed than just using simplistic public opinion polls. A WFE approach which incorporates social, cultural, economic and psychological aspects is considered to be one such holistic way of evaluating the UC scheme and an outline of a suitable methodology for applying this approach is discussed in Chapter 3.

It should be noted that this approach does not completely discount the current methods of evaluation that exist in research into contemporary health services. However, this research aims to consider health and healthcare from a wider perspective, namely that of wellbeing.

## **1.4 Research Objective**

- To evaluate the impact of the UC scheme on villagers in Northeast Thailand using a wellbeing approach.

The key research question being:

- To what extent has the UC scheme contributed to the wellbeing of villagers in Northeast Thailand?

## **1.5 Research Methodology and Techniques**

The thesis objective is to evaluate the impact of UC on villagers’ wellbeing in two villages (one remote and one non-remote) in Northeast Thailand. In order to achieve this objective, a multi-method approach is used, comprising qualitative and quantitative research methods (see Chapter 4). The methods used in both villages include:

1. Secondary data from the WeD (Community Profile, Resource And Needs Questionnaires (RANQ) and the WeD-Quality of Life –WeDQoL)
2. Questionnaire survey

3. Focus groups (semi-structured interview guidelines)
4. In-depth interviews
5. Policy makers / healthcare workers / key informants interviews
6. Participation observation, recorded in the researcher's field notes.

The samples for the research were selected with reference to: gender, social and economic status, age and location. The questionnaire surveys were carried out amongst 216 people in both villages, the in-depth interviews totaled 24 and there were also 6 focus group discussions. In addition, various stakeholders (healthcare workers and policy makers) were also interviewed, so as to obtain informed opinion regarding the healthcare provision to the villagers and their level of wellbeing.

## **1.6 Organisation of the thesis**

The thesis is divided into three main parts. The first part presents general background concerning the UC scheme, reviews the relevant literature and proposes a new approach to evaluation for this research. The second details the research methodology and describes the research context, with reference to the villagers' backgrounds, *vis-à-vis* their: history, culture, religious beliefs and access to healthcare. The third and final part analyses the data and is followed by discussions regarding the impact of the UC on the wellbeing of villagers as well as an assessment of the value of using a WFE approach. The three main parts break down into eight chapters as follows:

### **Part 1 Background to the UC scheme and the WFE approach**

The second chapter outlines factors which are related to the emergence of the Universal Health Insurance Coverage (UC) scheme and its subsequent development in Thailand. The first section contains a general discussion on the determinants of health and how people's health problems differ according to individual socio-economic and environmental factors. The second section highlights the major factors that influence access to healthcare, such as location, gender, economic class and age. In the third section, the development of the UC scheme in Thailand is examined, with particular reference to the socio-historical context in which it has emerged and the internal and external factors of relevance. The chapter concludes with a detailed discussion of the UC system and the ongoing debate with regards to its advantages and disadvantages.



The third chapter outlines relevant literature concerning healthcare evaluation and introduces the Wellbeing Focused Evaluation (WFE) approach. It begins with a review of conventional healthcare evaluation and this is followed by a more specific healthcare evaluation in the context of the UC in Thailand. The second section discusses the wellbeing concept in the health and healthcare dimensions, firstly with regards to the concept itself and then how it can be applied to Thailand. The third section introduces the broader concept of wellbeing into healthcare evaluation. The chapter concludes with a proposal for a WFE approach, one that proposes how to incorporate other factors such as geography, gender, economic class and age.

## **Part 2 Research Methodology and Context**

The fourth chapter contains a discussion of the research methodology, which describes how data was collected in order to answer the research questions. The fieldwork employed a number of quantitative and qualitative methods. The multi-method that was used included: in-depth interviews, focus groups, questionnaire surveys, case studies participant observation and some of WeD's methods.

The fifth chapter places the two research sites in their Northeast Thailand context and begins with a description of the northeast of the country (or '*Isaan*') and its history. It outlines the social, political and cultural nature of the region and relates this to the wider process of development in Thailand. The discussion highlights the subordinate position of the region that has emerged from its ethnicity (Keyes, 2005), regional position (Phillips and Berman, 2003; Berman and Phillips, 2000) that has created the conditions for participation in the development process. The chapter also provides data on the socio-economic characteristics of the villagers in both communities. The chapter ends with a discussion of the villagers' levels of access to healthcare based on their different factors: geographic, socioeconomic and cultural and lifestyle.

## **Part 3 Analysis and discussion**

The sixth chapter discusses the uptake and use of the UC card. It presents empirical data from the questionnaire survey and the responses from interviews at both the individual and group levels. The chapter begins with a discussion of the importance of health, with the purpose being to illustrate the extent to which the villagers in this study understood and valued the concept of good health. The second section explores the

level of uptake of the UC scheme by villagers in terms of their different locations, genders, ages and economic classes. This section also discusses ‘who has the UC card and who has not’ and the reasons for this. The third section then examines the utilisation of the UC card by villagers according to their different profiles. The discussion draws on: the Theory of Human Needs (Doyal and Gough, 1991), the Resource Profiles Approach (RPA) (Lewis *et al.*, 1991; Lewis and McGregor, 1992), Sen’s capabilities approach (Sen, 1999), and previous findings of WeD’s Resource And Needs Questionnaires (RANQ).

The seventh chapter provides a more detailed analysis of the villagers’ satisfaction with the UC scheme and investigates how the satisfaction with the UC scheme transfers to villagers’ contentment with their lives in general. The analysis of the contribution of the UC scheme to the villagers’ levels of satisfaction with their lives considers the villagers’ contentment with using the UC card, according to differences in location, gender, age and economic class. Moreover, using the same categories, reasons for dissatisfaction with the UC scheme are also discussed. The discussion draws on the Theory of Human Needs (Doyal and Gough, 1991), Sen’s capabilities approach (Sen, 1999), previous WeDQoL findings (WeDQoL, 2006), and the importance of Buddhism and the monarchy in villagers’ everyday lives. To gain an understanding of the villagers’ actions and motivations when using (and not using) the UC card, this part discusses the different reasons that were offered, referring to case studies.

The eighth and final chapter contains further discussion and the conclusion, with regards to the effect of the UC scheme on the wellbeing of the villagers in the communities researched, that is, an assessment is made of the impact of the scheme on both the remote and the non-remote village. This is followed, in the second section, by a consideration of the strengths and weaknesses of the UC scheme. The third section assesses the value of a wellbeing evaluation approach and discusses its limitations. The fourth section considers policy implications with regards to the social, political and cultural contexts of Thailand and the country’s present development goals. The last section puts forward recommendations for future research in this area of study.

## **Chapter 2: Healthcare and policy developments in Thailand: the background to the Universal Health Insurance Coverage (UC) Scheme**

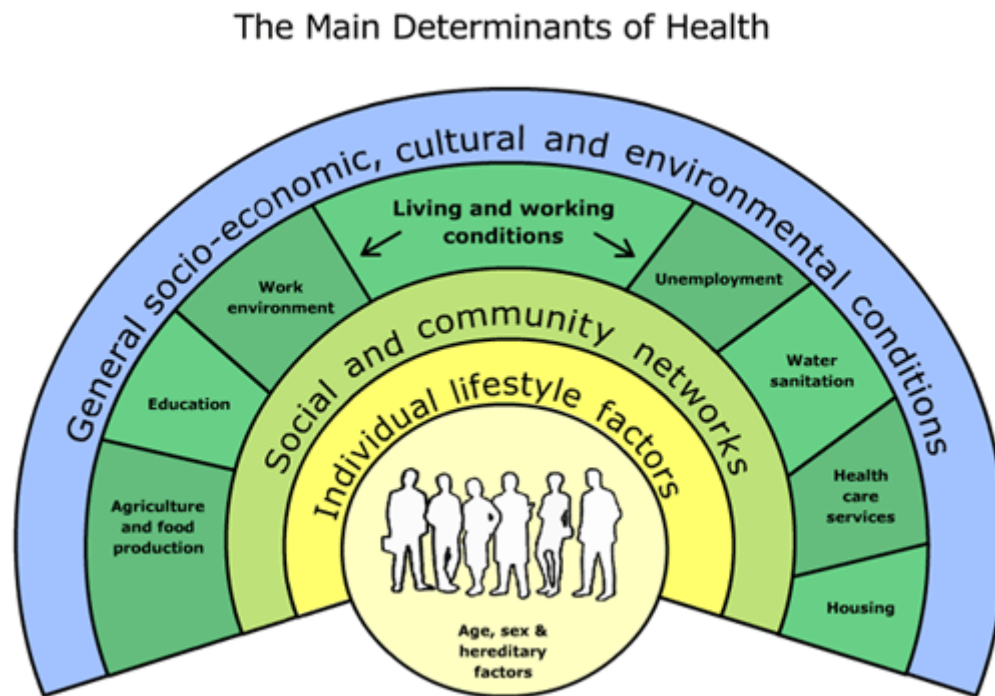
The policy of providing universal coverage in Thailand has taken a considerable period of time to develop, has been influenced by a number of different factors, and has emerged from various theories and policies proposed by internationally renowned academics and agencies. This chapter discusses these developments, so as to get a clearer understanding of what the UC scheme is, and how and why it has come into being. It is divided into four sections as follows.

In the first section the determinants of health are discussed and it is posited that access to appropriate healthcare is an important factor for people's health. The second section highlights several types of inequity that affect access to healthcare; these stem from geographical and socio-economic factors and impact differently according to: location, gender, class and age. The third section introduces the external and internal factors affecting the emergence of the UC in Thailand: influences from global initiatives and the nation's recent political, economic and social changes. The fourth section introduces the UC scheme, its application, and positive and negative responses to the scheme from, for example, academics, politicians and the media.

### **2.1 Underlying determinants of health**

The determinants of health are explained by certain factors, starting with the individual and extending to aspects of the wider community. Figure 2.1 shows a famous representation, which indicates the main factors and links between: individuals, social and community networks, living and working conditions and socio-economic, cultural and environmental conditions (Dahlgren and Whitehead, 1991).

Figure 2.1 The main determinants of health



Source: [www.pharmacymeetspublichealth.org/images/healthdeterminants-diagram.gif](http://www.pharmacymeetspublichealth.org/images/healthdeterminants-diagram.gif)

Evan *et al.* (2004) asserted that each of these areas have an important role in addition to the role played by biological factors (e.g. the presence of disease pathogens) in determining people's health.

Firstly, factors such as gender, age, genetics and lifestyle have an effect on an individual's health. For instance, while gender is an individual characteristic, it is also a social category in that the differential treatment of women and men affects their health. Lifestyle, likewise, is often as much a product of environment as of individual choice, and thus health-related behaviours can also be categorised under environmental factors.

According to Ministry of Public Health (MoPH) (2007), the 1999 and 2004 DALYs<sup>5</sup>, which take into account risk factors, showed that health behaviours were different between Thai males and females. For example with regards to smoking, in 1999 the rates were males 8 % and females 1% and for alcohol consumption these were 9 % and

<sup>5</sup> Disability Adjusted Life Years or DALYs are the sum of the years of potential life lost due to premature mortality and the years of productive life lost due to disability (WHO accessed 2007)

1% respectively. These male to female rates increased, in particular among male, to 9 % and 2 % for smoking and 13% to 1% for alcohol consumption.

Secondly, environmental factors affect health conditions, in both the physical and social dimensions. Factors from the physical environment have a profound effect on mortality and morbidity and these may range from birth defects caused by pollutants, to various childhood diseases. According to the WHO (2007), approximately two million children across the world die each year from diarrhoeal diseases linked to inadequate water supplies. In particular, in developing countries, children are especially at risk from diseases that are increasing in frequency due to global warming, such as malaria and dengue fever (UNICEF, 2007)

Thirdly, socio-economic factors and having a stable political system in a country are major determinants of health. Socio-economic factors are considered to be those of: education, income, and social class (Evans *et al.*, 1994; Wilkinson, 1992; and Farmer, 2004). Numerous studies have shown how socio-economic factors may influence health. For example, in Britain's 'Whitehall Study', a cohort found that the morbidity and mortality rates of civil servants are graded by socio-economic status, even though the participants had equal access to the NHS (Marmot, 1986; Marmot *et al.*, 1987; cited in Evans *et al.*, 1994). Even when behaviours were controlled for, people situated lower in the social hierarchy were still less healthy and had a higher incidence of mortality. Wilkinson (1992) hypothesised that ill health was also related to the stress of having high responsibility but low control in the work tasks undertaken by individuals from lower social groups. Other well-known studies which have shown how socio-economic inequalities influence health in the UK are the 'Black Report' (Office of Population Censuses and Surveys OPCS, 1972; cited in Evans *et al.*, 1994) and the 'Social Gradient' study (Smith, G. *et al.*, 1997).

The WHO (1998) published a report entitled 'The Solid Facts' that identified the ten factors which they considered to be determinants of health. These factors are:

1. The social gradient <sup>6</sup>
2. Stress
3. Early life
4. Social exclusion
5. Work
6. Unemployment
7. Social support
8. Accident
9. Food
10. Transport

According to the WHO (2003), poor people have substantially shorter life expectancies and more illnesses than the rich. The latter point has been supported by the work of Farmer (2004) who provided numerous examples to show how poor people in Haiti, particularly those in marginalised groups, became sick because they were poor and powerless and this he termed ‘structural violence’. According to him, structural violence affects health at all levels - whether people are exposed to disease, if they have the physical resources to withstand it, and whether they can afford healthcare under a market-oriented healthcare system. In Farmer’s view, healthcare is a basic right that the poor deserve as much as the rich do, and he recommends national health insurance, which promises equal access to healthcare regardless of social status (Farmer 2004).

The discussion above has indicated that many factors, apart from healthcare service as illustrated in Figure 2.1 above, determine people’s level of health. However, it cannot be denied that access to a good healthcare system is one of the factors that remains crucial to restoring people’s health when they become ill. Evans *et al.* (1994) concluded that the availability and use of healthcare is vital to the health of individuals and populations. Healthcare is considered one of the main strategies available to governments for maintaining and improving people’s health. As the WHO (2000) stated, ‘healthcare includes all the goods and services designed to promote health, including preventive, curative and palliative interventions, whether directed to

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<sup>6</sup> People at different levels of the hierarchy have different risks of diseases. For example, a ‘Whitehall study’ by Marmot (1986) found that the lower a person was in the hierarchy, the higher the risk of diseases. On the critically important role of inequality in leading to ill health, see Marmot, M. et al (1997) and Farmer, P. (2004).

individuals or to populations' (WHO, 2000: 6). Hence it can be seen that healthcare comprises several activities and is directed towards both individuals and groups at various points, such as towards families, communities and nations. Health improvement may be considered the main objective of a nation's healthcare system, and equally, this goal may result indirectly from other social interventions, such as through the education system. For example, the positive effect of improved maternal education on child health (WHO, 2000).

Many studies have confirmed that access to appropriate healthcare can improve people's health. Jones *et al.* (2003) pointed out that approximately two-thirds of the under five years old child mortality rate in developing countries could be prevented by basic healthcare interventions, such as providing an oral rehydration solution. Jones *et al.* (2003) and Bryce *et al.* (2003) found that effective healthcare interventions such as vaccines and diagnostic methods, i.e. access to trained medical personnel, reduced the number of child deaths in low income and middle income countries. According to Bryce *et al.* (2003), referring to UNICEF's statistical report of child mortality rates for 2001, the availability and use of healthcare through a public health system could reduce this rate. Moreover, in developing countries, improvements in access to healthcare could benefit mothers and their children, reducing the mortality rate from pregnancy-related and childbirth-related diseases (Jones *et al.*, 2003; Bryce *et al.*, 2003; Tsu, 2004). According to the WHO (1999, cited in Tsu, 2004), 25% of maternal deaths were caused by haemorrhage during birth. WHO estimated that, annually, 14 million pregnant women experienced haemorrhages, but that preventive measures and early treatment could save the lives of these mothers.

The examples above underline the importance of healthcare and access to it. Unsurprisingly, access to healthcare has been regarded as a fundamental human right for about a half century, as seen in the Universal Declaration:

'Every one has the right to a standard of living adequate for the health and wellbeing of himself [sic] and his family [sic], including food, clothing, housing and medical care and the right to security in the event of ...sickness, disability...' (The Universal Declaration of Human Rights, 1948, Article 25).

According to this, all people have the right to an equal opportunity to access primary healthcare facilities. However, there are still many people struggling for equal access to healthcare in both developing and developed countries. This inequality has caught the attention of many organisations across the world, including that of the WHO. The WHO has promoted universal good health for people since the middle of the 20th century. For example, in 1978, the International Conference on Primary Health Care that was held in Alma-Ata called for a radical change in both the content and design of health services. This was aimed at fostering equality in health services through putting the focus on primary healthcare with the goal of providing ‘health for all’ in the 21st century (WHO, 1997).

The WHO has attempted to resolve the problem regarding the inequity of access to healthcare and continues to consider access to healthcare for the poor a fundamental concern (WHO, 1997). Many strategies have been proposed in order to broaden the concept regarding healthcare from that of ‘market-oriented’ to that of ‘human rights’, under which everyone, regardless of their class and income could access healthcare services. In 2006, the WHO produced a document entitled ‘Engaging for Health’, which put forward seven measures in the form of a ‘global health agenda’ that had the target of decreasing health inequities. These were as follows.

**Box 2.1 A Global Health Agenda**

1. Investing in health to reduce poverty
2. Building individual and global health security
3. Promoting universal coverage, gender equality, and health-related human rights
4. Tackling the determinants of health
5. Strengthening health system and equitable access
6. Harnessing knowledge, science and technology
7. Strengthening governance, leadership and accountability

Source: WHO (2006)

From this initiative, it can be seen that the WHO considered the promotion of ‘universal healthcare coverage’ as crucial. Moreover, it stated that solving health problems was not just the task of national ministries of health, but that problem solving needed to be linked to the resolution of other problems such as: poverty, low levels of education, social exclusion, and that this agenda involved political issues. Resolving health



problems required everybody's participation, ranging from the individual up to the community and the global arena. Thailand has been a member of the WHO since 1948. Her membership is important to the discussion of how the emergence of the UC scheme was affected by external and internal factors. This will be discussed further in section 3 of this chapter.

Although addressing healthcare inequities is a global goal, in reality there remain substantial inequities in access to healthcare in many dimensions: between countries, between socio-economic groups and between individuals. Therefore, individuals do not only face differences in the factors which determine their health, but also face unequal access to healthcare. The inequities in access to healthcare are explored in the following section.

## **2.2 Healthcare access and inequity**

Socio-economic factors influence whether people have good or bad health and they greatly influence the level of access that people have to healthcare services. The WHO (2006) reported that lack of income, inappropriate housing, unsafe workplaces, and lack of access to health systems were some of the pertinent social determinants of health.

To start at the national level, the degree of development in the country in which people reside, can affect their health. World health statistics demonstrate that people living in developed countries live longer than those living in developing countries (WHO, 1999). Marmot (2001) showed that life expectancy was higher in rich countries than poor countries, however, he found that even rich countries, such as the United States, still exhibited great inequities with regard to healthcare between 'White men' and 'Black men'. He writes

‘The 20-year gap in life expectancy between whites in the healthiest countries and blacks in the least healthy is as big as the differences between countries at very different stages of economic development’ (2001: 134).’

Whereas the low life expectancy in poor countries may be the result of starvation, infected water, infectious diseases, a lack of nutrition and poor sanitation, the low life expectancy of people who live in poor areas within rich countries is not. Socio-

economic characteristics such as income, education, and occupation are impacting on people's health (Marmot 2001).

Lack of access to healthcare systems and inadequacies in the delivery of healthcare services are found in certain developing countries, including Thailand. These problems exist primarily because of limited financial resources when, for example, the nation earns little revenue from exports and taxation. A 'vicious circle' that hinders development can occur, in that limited government expenditure results in lower living standards and education levels, and a lack of basic infrastructure and necessary medical technology. Inadequate healthcare services then contribute to the bad health of the population, as seen in: low life expectancy, high death rates of newborn babies, and a high risk of being ill. In turn these become obstacles to economic development that hinder economic growth and thereby perpetuate bad health scenarios (Yiengprugsawan, 2007; Boonyeun, 1998).

Inequality in access to healthcare is found in Thailand. According to Tangchareonsathien(1996), the education, occupation and income levels of the head of the household are related to this unequal access to healthcare. Moreover, the poor are more likely to have to pay out-of-pocket fees than the rich (Pannarunothai and Mills, 1997) with an inequitable pattern of out-of-pocket health expenditure when assessed by income quintile and per capita. For underprivileged groups in Thailand, the cost of healthcare often forms a high proportion of their overall household income, as compared with people from more privileged groups. Thais who live in rural areas have been found to have less access to healthcare facilities than those in urban areas (Sreamsee *et al.*, 2003) and in many cases, rural villagers were not able to receive immediate treatment because of the distance to be travelled to reach healthcare centres in cities. Some reports state that there have been cases of individuals having died before they reached help (Public Health Commission, 2002).

In summary, many factors affect people's access to healthcare services. In the particular case of Thailand, factors that affect people's abilities and opportunities to enjoy healthcare services range widely from geographical factors to individual attributes, such as education, occupation and economic class. For the remainder of this second section, the specific issues of location, gender, age and class will be discussed, drawing on

studies that provide information about a range of developing countries as well as Thailand.

### **2.2.1 Location**

Distance from healthcare providers is known to be an important factor, with people living in urban areas generally having better access to healthcare services than those living in rural areas. For example, the Demographic and Health Surveys undertaken in 20 countries between 1990 and 1994, reported that the rural child mortality rate was 45% higher than the urban rate, and that timely access to appropriate healthcare was clearly a determining factor in this (Gwatkin, 2000). In the case of the Thai population, prior to the adoption of the UC scheme, it was found that those who were excluded were predominantly found to be located in rural areas (Sreamsee et al., 2003). Khanthachai (1983) studied two villages in rural Thailand and noted a lower level of access to government services in the remote village, which resulted in villagers being less satisfied with their healthcare and having a lower standard of living. Twenty years later, Na Ranong (2003) confirmed that location was still a crucial factor in rural areas, regarding access to healthcare, even after the introduction of the UC scheme.

According to Hirsch, the majority of Thai people live in rural areas. Hirsh writes that ‘nearly four out of five Thais live in the countryside’ (1990:2). However, in recent years the industrial and service sectors have been the leading sectors in the Thai economy. These tend to be urban-based. So even if two thirds of the population still worked in the agricultural sector in the early 1990s, agricultural production accounted for only one sixth of the Gross National Product (GNP) (ibid, 1990). This demonstrates that inequities between rural and urban areas have emerged from past and more recent development strategies. In particular, the Northeast of Thailand has been experiencing inequalities in terms of income distribution, which are indicated by the high incidence of poverty (Phongpaichit and Baker, 2000). The Northeast region is not only known as the poorest region in terms of income distribution, but it has also suffered from having a less important position than ‘Thai’ citizens in other regions (Mattariganond 2000; Keyes 2005). This issue is significant and will be discussed greatly in the context of research in Chapter 5 as it is related to the way in which villagers think about the UC scheme in Chapter 7.

Recently, debates on the relationship between rural and urban areas have continued to evolve. Several studies show the linkages between rural and urban areas in terms of movement of people, goods, capital and other social transactions (Tacoli, 1998). The well-known definitions of rural and urban are often referred to as accounting for population, occupation and administration. However, the differences are often not clear and can be more complex (ibid, 1998) than the ways in which nations classify rural or urban areas.

In the case of Thailand, communities can be roughly classified into two types: rural and urban. The nation defines the distinction between rural and urban through six main categories: population density, importance of relatives, education, political participation, administration, and the importance of religion and culture (Valaisathien, 2000). However, the differences between rural and urban are not clear as a widespread process of urbanisation has taken place and many rural villages have been transformed into 'modern' sites that have many urban characteristics.

Despite the reduced distinction between rural and urban areas, inequities between the two are still ongoing. For example, the number of doctors and health workers is still disproportionately inadequate in rural areas, as most health personnel tend to be clustered in cities. The lowest percentage of healthcare staff per head of population is in the Northeast, as compared to other regions and Bangkok. For example, in 1979, the doctor to population ratio in Bangkok was (1: 1,210) whereas in the Northeast region it was (1: 25,713). Twenty-five years later, in 2004, the gap had improved, but Bangkok still maintained ten times as many doctors per capita as the Northeast region, with a ratio of 1:767 compared to 1:7,251, respectively (Ministry of Public Health, –MoPH, 2004).

In order to improve healthcare access between rural and urban areas, the MoPH invested in the infrastructure of health units in every district and sub-district throughout the 'Decade of Health Centre Development', which ran from 1986 to 1996 (MoPH, 2005). After the introduction of the UC scheme, Primary Care Units (PCUs) were developed to expand the range of services and improve the quality of care amongst providers working far from urban centres. However, there remained limitations regarding the number of physicians who were willing to work for small community hospitals and PCUs, so that in practice, people in rural areas continued to have reduced chances of receiving

medical consultations (Pannarunothai, 2005). This suggests that geographical factors influence access to healthcare, because more services are provided in non-remote locations. Automatically, therefore, there will be inequities in access to healthcare, in terms of higher transport costs and travel times for remote villagers in comparison to those living in urban areas.

Distance from healthcare facilities is not the only factor of note. According to Timyan (1993), although women and girls in urban areas have better access to healthcare than women and girls in rural areas, their access to resources for expenditure on healthcare in both urban and rural areas has been found to be less than that available to men and boys (Timyan, 1993). Access to healthcare services emerges as complex and multifaceted. Gender is the next factor to be discussed.

### **2.2.2 Gender**

A substantial body of literature exists indicating that gender, both biological and social roles, significantly influences access to healthcare (Miles, 1991; Doyal, 1995:1998; Standing, 1997; Boonmongkol *et al.* 1999; Annandale and Hunt, 2000; and DeLorey, 2003). This is because women and men are not only different in terms of physical characteristics, but also in their health needs. It has been observed that many female English patients (65.5 %) prefer to seek advice and care from female GPs, particularly with regard to their reproductive health and women's health issues (Phillips and Brooks 1998). The reasons they gave for this are: female GPs have a better personal understanding of women's health problems than male GPs and female GPs provide more counselling and time with them.

In many cases, gender role is found to be an important factor in access to healthcare. For example, in some countries women often lack access to healthcare because men have more power to decide the finances necessary to purchase medicines and pay for doctors' appointments. Moreover, women have fewer opportunities to participate in the decision-making process regarding access to healthcare facilities and which services are available. According to the UNDP (1997), in Africa and Latin America women have poorer health, education and economic status compared to men. This has also been found to be the case in India and China (UNDP, 1997). Such gender inequalities lead women to have serious health problems and millions of women have died or possibly

not even been born as a result (Sen, 1990; Klasen and Wink, 2003, cited in UC Atlas of Global Inequality, 2004).

Following on from this, in most countries, it has been recorded that male mortality exceeds female mortality but in general, the female health status is poorer than that of male. This disparity in health status may be explained by a number of reasons. Firstly, women suffer disproportionately from chronic diseases and malnutrition, and secondly, women have poor access to healthcare and treatment. They reportedly lack access to safe methods of contraception, suffer from reproductive tract infections and have few reproductive rights (AbouZahr and Vaughan, 2000, cited in Women and Health Program, 2003). These gender disparities can be strongly linked to the fact that more women suffer from poverty than men, especially in parts of the developing world (United Nations Development Programme -UNDP, 1997).

‘In developing countries there are still 60% more women than men among illiterate adults, female enrolment even at the primary level is 13% lower than male enrolment, and female wages are only three fourths of males wages’  
(UNDP, 1997: 39).

In case of Thailand, the situation for women reveals a slightly different picture. They may have improved their health, education and economic status as compared to men (Mee-udon and Itarat, 2005). According to Mee-Udon and Itarat (2005) there are more men than women with HIV and men commit suicide more often than women. In the field of education, women’s literacy rates have improved, although there are still more women than men unable to read or write, and the number of women in higher education has dramatically increased. Regarding economic status, many women make the household decisions and may have more economic power than men in terms of controlling income and other household economic resources (Mee-udon and Itarat, 2005; Blumberg and Mee-Udon, 2002; Promphakping, 2000). Therefore, given these improvements, it may be reasonable to suggest that Thai women possibly have better opportunities for accessing healthcare facilities.

Examples previously taken from women around the globe illustrate that gender plays a significant role in both advantage and disadvantage in access to healthcare. White (2006) found that culture affects the way in which women (and men) seek

healthcare in Bangladesh. Similarly, Achavanigul and Boonmongkol (1999) pointed out that in order to understand women and their health, invisible factors such as culture, norm and religion should be considered.

However, it is important to recognise that men and women are similar in that their gender roles have been constructed and sometimes constrained by stereotypes. Many women and men are unable to move beyond such stereotypes, even though the contemporary world is continually changing. The issue of ‘missing men’ in development projects and social policies has been widely discussed among scholars (Cornwall and White 2000; Pearson 2000), including in terms of health and gender (Pearson 2000).

In summary, the relationship between gender and inequalities in healthcare access is complex. Thus, it must be noted, that women and men are not a homogenous group and diversity exists within each gender category. For instance, both men and women fall into all of the categories of: rich, poor, old and young. Any study into healthcare inequalities needs to take this fact into account if it is to maintain rigour.

### **2.2.3 Class**

This section examines inequity in healthcare in terms of class. It starts with an international perspective and then focuses on Thai society in particular.

In most countries, the poor have less access to medical services than the rich, but poverty, as regards healthcare, is not due to lack of income alone. There are also issues surrounding the denial of opportunities and choices. These choices are fundamental to human development and cannot always be objectively measured (Sen, 1999). The Human Development Report described this argument about choices as enabling individuals ‘to lead a long, healthy, creative life and to enjoy a decent standard of living, freedom, dignity, self-esteem and the respect of others’ (UNDP1997: 5).

Barriers to healthcare are found to be linked with the class system in Thailand. According to Pongsapich (1996), class divisions have been a feature of Thai society for centuries. In the past, the ‘*Sak-di-na*’ system was used to determine social class. Access to the ‘*Sak-di-na*’ class was based on the amount of land one owned, and the more land one owned, the higher the status. At the village level, three classes, rich, middle and

poor, operate and people are separated according to their economic and social status, which is determined by the amount of land owned, appearance of the household dwelling and occupation (Pongsapich, 1996). However, land ownership is no longer the only factor which distinguishes villagers, as off-farm activities and income generation may be more important: social status, education and occupation are significant according to Potter (1976). The class system still exists in Thai society today and it has been found that the rich are given priority in accessing healthcare resources and are treated with more respect than the poor (see, for example, Khamleung, 2002, Pannarunothai 2005).

Pannarunothai (2008) pointed out that inequalities in health are due to different levels of household income, educational attainment and type of occupation. Inequity in the financing of healthcare was clear in that the underprivileged (the poor and the uninsured) paid a higher percentage of their household income on out-of-pocket healthcare expenses than the privileged. There is evidence that access to healthcare creates a loss of household welfare among many poor people. A study on catastrophic illness<sup>7</sup> in Thailand (Sujariyakul, 2000, cited in Pannarunothai, 2008) found that 24 % of uninsured inpatients experienced great difficulty due to their illness. Their hospital bills exceeded their household income. Most of these patients were in unskilled jobs and had received little education. To cope with their problem, 3.2 % had got into debt and 0.2 % had had to remove their children from school. However, this percentage of household income spent was reported to have fallen following the introduction of the UC scheme (see findings in Chapter 6).

Thai society is very hierarchical, which results in the available resources being allocated unfairly amongst the different groups. For example, government officials often have more privileged status compared with villagers and will receive benefits such as those provided through the Civil Service Medical Benefit Scheme (CSMBS). As with the ‘vicious circle’ argument regarding the poor described at the beginning of this section, the same can be applied to this group in terms of healthcare. That is to say, when the poor get sick, they cannot afford to access expensive healthcare and hence they remain sick, are unable to work and so remain poor. Moreover, where the level of education

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<sup>7</sup> This refers to severe illness requiring prolonged hospitalisation or recovery; usually involving high costs for hospitals, doctors and medicines <http://www.thefreedictionary.com/catastrophic+illness>



and income are low, households are unlikely to be able to pay much attention to every member's health and thus it is possible that these factors perpetuate illness. It may be the case that, in some sections of society, this phenomenon still occurs in Thailand today.

In 1996, drug consumption of Thai people accounted for 35 % of the overall health expenditure. This is rather high compared with 11.8 % in the Organisation for Economic Cooperation and Development OECD countries (Tangcharoensathien 1996). The Ministry of Public health (MoPH) affirmed this data and the rates increased to 42.8 % for Thailand and 10-20% for OECD countries in 2000 (MoPH 2007). Tangcharoensathien (1996) reported that before the UC scheme was instigated poor people had very limited access to healthcare. In addition to this, many of the poor rely on 'self-prescribed drugs' more than the rich (Tangcharoensathien *et al.*, 2004, cited in Panarunothai, 2008). This leads to the poor receiving unsafe drugs and puts their health at risk still further.

The low level of access to healthcare among the poor is also associated with other factors, such as inequality in income distribution and resource allocation, which reinforces differences between the rich and the poor regarding their level of health. Tangcharoensathien found that in 1996, nearly a third of the Thai population had no health insurance and all of them would be defined as 'poor<sup>8</sup>', because of their low income. Tangcharoensathien attributed these problems to 'the pro-private, pro-market state healthcare system' (1996:20) and argued that all health systems needed to be reformed in order to achieve greater efficiency, equity and the extension of insurance coverage to the entire population: poor, rich, old or young.

#### **2.2.4 Age**

Aday *et al.* (1993) pointed out that age is a significant factor associated with the use of different types of medical care. People of different ages use healthcare services for different reasons and some only use them very rarely, if at all.

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<sup>8</sup> The 'poor' was defined as 'person with low income (less than 1,000 baht a month) and a family with low income less than 2,000 baht a month'.

Several studies found age discrimination in healthcare services (Garner, 2000; Department of Health 2001). For example, Garner (2000) pointed out that older people are treated less favourably because of their age, in particular elderly patients in long-stay settings. This indicates that age is perceived to have an effect on equity of access to healthcare services.

In the case of Thailand, the issue of healthcare and the elderly has become more of an issue to the government and to academics because of the increase in the percentage of the population who are old, which rose from 5.4 % in 1980 to 11 % in 2006 (WHO, 2007). In order to administer welfare to these people, the government has provided free healthcare for all old people, that is those over 60, since 1994 (NHSO, 2004).

One study of the 'Health for all 2000' project in Thailand found that age was a positive variable in terms of the level of satisfaction with healthcare treatments. That is to say, the elderly had higher contentment than other age groups over medical provision (Kamnuansilapa *et al.* 2000)

This could be explained by the fact that in Thailand older people are revered, as found in the notion of '*Boon Koon*'. This refers to their having gratitude conferred on them by the younger generations through cultural and socialisation process. In addition, medical workers are specially trained in how to deal respectfully towards the elderly (Benjakul, 2004).

This study takes age into account in analysing the impact of the UC scheme on the wellbeing of people. It investigates how people in different age groups utilise the UC scheme and how far they are satisfied with the scheme.

From the above, it can be seen that healthcare inequity derives from many factors such as location and socio-economic status, as well as demographic characteristics such as gender and age. In other words, these factors have a significant effect on how people access and utilise healthcare services and the quality of the care that they receive. To analyse the impact of a healthcare scheme it may be necessary to consider all the possible factors which are involved. However, this present study specifically focuses on the factors covered above, namely, those of location, gender, age and economic class.

## **2.3 Emergence of the concept of universal provision and the Universal Coverage Scheme in Thailand**

As stated in the introduction to this chapter, the introduction of the UC scheme was influenced by many factors, including global health initiatives, and it has developed gradually over a considerable period of time. In this respect, the UC scheme was developed from the concept of ‘modern healthcare’ in addition to the Thai healthcare system in which based on ‘Thai wisdom’ and ‘oriental wisdom’ (MoPH, 2004). Thailand has had contact with the West and has been influenced by modern healthcare thinking since the beginning of the Rattanakosin period (1782 onwards). However, in the modern era, one key influence has been the WHO, from which the definition of health, and perspectives regarding health, have been adopted to form the particular features of the Thai health sector (MoPH, 2004).

Major social reforms across various aspects of life, including the arenas of politics and economics, have taken place in Thailand owing to the people’s power and support from international organisations such as the WHO, the Asian Development Bank (ADB) and the European Union (EU) (Wongkongrathep *et al.*, 2004). In this context, the roots of the UC scheme lay in the debates that arose, regarding political and healthcare reforms, after the economic crisis of 1997. Thus, the UC scheme in Thailand emerged from a combination of external and internal factors, the former involving academic and economic support from the international community and the latter the present structure of the country and political will of the Thai people.

### **2.3.1 External factors**

#### **2.3.1.1 Universal Coverage: a global strategy**

Improving access to healthcare systems so that there is universal coverage has become a strategy in many countries of the world. The concept of health insurance, centred on the idea of ‘available to all’, has been influenced and fostered by the WHO, a powerful organisation in the global arena.

Initially, Thailand adopted the WHO’s definition of health according to the WHO 1946 constitution, ie that health is ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 2004). Explicit in this definition is the notion that health refers not only to whether the person has an illness or

not (something that can be externally observed), but also acknowledges the subjective effect of socio-economic and psychological factors. The WHO measure of health includes ‘social relationships’ and more recently ‘spirituality, religion and personal beliefs’ (WHO, 1998), which extends health beyond physical and mental aspects.

Physical and mental health can be seen as part of personal health, while social and spiritual health concern social connection, values and beliefs. Social health is of increasing interest both in practice and academia (WHO, 1998) and encompasses related concepts such as social capital, participation, and intimacy. It means that a person is able to live in society without experiencing contempt, discrimination, oppression or exclusion. While ‘spirituality, religion and personal beliefs’ has been added as a component of health, and the effect of spiritual beliefs and practices is increasingly studied (for example, the role of meditation in alleviating chronic pain), the interpretation of this term is contentious and discussion continues about the best way to measure it (WHO 2001).

Thus it is clear that the scope of health definitions is shifting from conceptualising health as simply the absence of illness to a new holistic perspective, and this change is also evident in Thai health discourses (Jongudomkarn 2006; Camfield 2006). The meaning of health in the new concept refers to a state of physical, psychological and spiritual wellbeing and the factors required to achieve this, for example, ‘environment’ and ‘level of independence’ (WHOQOL 1995). Changes in the meaning of health will be discussed in the next chapter because it provides the rationale for why the wellbeing focused evaluation is needed for evaluating the UC scheme.

Moreover, in order to make people healthier, Thai policy makers have adopted various ideas from the WHO, for instance: ‘Primary Health Care’ and ‘Health for all by the year 2000’ (Alma-Ata Declaration in 1978<sup>9</sup>), individual ‘Health Promotion’ (Ottawa Charter in 1986<sup>10</sup>), and the focus on healthy environments in ‘Healthy Settings’ (Jakarta Declaration in 1997<sup>11</sup>) (Wongkongrathep *et al.*, 2004).

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<sup>9</sup> Health volunteers were used as a key mechanism to attain a health strategy for the people by the people. In addition, a community development programme called the ‘Basic Minimum Need’ approach was implemented.

<sup>10</sup> Building a healthy public policy in the community and reorientation of health services to achieve this.

<sup>11</sup> The health status of any setting is determined by the quality of the environmental conditions and the presence of risk factors, rather than the healthcare facilities provided.

In 2000, the WHO produced a world health report examining a ‘new universalism’ regarding healthcare that would mean that everybody would be able to access necessary, high-quality medical treatment (World Health Report 2000). Furthermore, this report aimed to ensure that governments and leaders worldwide would improve domestic healthcare systems and would also try to increase the health of the population. Several campaigns and movements within the health system in Thailand that coincided with this ultimately led to the drafting of the National Health Act (NHA) 2001 and the major legislation affecting health insurance. These are discussed in the following section.

To understand the health insurance system in Thailand, it is crucial to learn about other systems worldwide. In almost every country where there is a government healthcare system, a parallel private system is allowed to operate. Thus there are two types of healthcare, one for the public at large and another for those who can afford to pay. This thesis focuses on the domestic Thai public healthcare system, although it acknowledges that private healthcare is a large and growing market in Thailand.

The concept of universal coverage has been applied across countries around the world. According to Haresnape (2000), three main systems have been widely used to finance public healthcare systems, namely the National Health Service (NHS), Social Health Insurance (SHI) and the National Health Insurance (NHI) system.

The first is the NHS, which has been used in the United Kingdom (England, Wales, Scotland and Northern Ireland) since 1948. Under this system, the government finances the healthcare programme through general taxes and also delivers all healthcare programmes.

The establishment of the universal coverage system in the UK is an interesting example given that its creation was part of the state welfare arrangement in order to respond to the demand of the middle class who represented the main force in British society after the Second World War (Powell, 1997). It was also part of a popular discourse of ‘making a land fit for heroes to live in’ to reward those who had served in World War II. The NHS currently provides services to almost everybody, although there is some private provision. The idea shares the same basis as the human right concept that each individual has equal basic right to receive free healthcare services from the state.

The advantages of the UK NHS system may be listed as follows:

- 1) The system is cost-effective as it is large, covering the majority of the population.
- 2) There is less of a problem of 'adverse selection'<sup>12</sup>.
- 3) It is possible to avoid the competition that exists when several health insurance systems are employed, which brings about inequities and inefficiencies. (Haresnape, 2000)

There are also criticisms, most notably that:

- 1) It takes a considerable amount of time to obtain services, particularly for operations which are not considered urgent (Haresnape, 2000).

The second system is Social Health Insurance (SHI). SHI was first introduced in Germany in 1883. This system funds the healthcare programmes through payroll and general taxes. Healthcare is delivered by the private sector. There are a number of governments around the world currently using SHI. Examples can be seen in parts of Europe, such as France, the Netherlands, and Hungary, in Latin American countries, such as Mexico, Argentina, and Brazil and in East Asian countries such as Taiwan, South Korea, and the Philippines (Barnighausen and Sauerborn 2002).

There are advantages as follows:

- 1) People receive guaranteed services.
- 2) People are allowed to choose where they would like to get services.

However, a criticism may be that

- 1) Certain services are still not widely offered, such as dental and optical services.

The third system is the National Health Insurance system (NHI). It is unclear when the concept of NHI originated. Under this system, the government finances the healthcare programme, but the healthcare services are provided by either the private or public sector. Many developing countries, such as Kenya, Israel, Egypt and Thailand, have adopted the NHI concept for their health provision.

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<sup>12</sup> The tendency of persons with higher health risks having to apply for insurance coverage to a greater extent than persons with lower risk ([http://www.spectruminsurancegroup.com/glossary\\_a.php](http://www.spectruminsurancegroup.com/glossary_a.php)).

The main advantage is:

- 1) People receive guaranteed services.

The main criticism is:

- 2) People are not free to choose where they would like to get services.

(Haresnape, 2000)

The creation of a universal coverage system in Thailand has been influenced by these international experiences and the health system reform, which is discussed in detail below.

### **2.3.1.2 Health system reform**

Thailand was influenced by the health system reforms that took place around the world during the late 1980s and early 1990s. The reformation of the NHS in the UK, involving moves towards general management rather than clinician-led decision making, and the separation of purchasing from providing functions in healthcare has had an influence on the nature of the health system reform in Thailand. In the United Kingdom, the healthcare system emerged in response to three specific concerns, all associated with industrialisation. These were demographic change, advances in medical science, and demand for a higher standard of care (Powell, 1997).

The recent health system reforms that have been developed in Thailand, according to Wongkongrathep (2004), have happened for similar reasons to those in Britain, but the context in which they have occurred is different. Two main differences can be identified. Firstly, the Thai government succeeded in launching policy reforms which had very strong support from large sections of the population, including many politicians and researchers in the health field. Secondly, only the public hospitals and those involved in public health provision have participated in the reforms (ibid, 2004). Additionally, according to Panarunothai (2000), during that time the MoPH received financial support from the European Union (EU) to carry out a Health Care Reform Project in order to raise the issue of health equity in Thai healthcare system.

### **2.3.2 Internal factors**

Political, economic and social changes which increased public demand for equitable access to healthcare services occurred in the mid/late 1990s. The 1997 constitution stated the right of citizens to access healthcare and in particular reiterated the notion of free care for the poor, as stated in the 1991 constitution. Moreover, the 1997 constitution confirmed this right by adding the principle of equity in healthcare access and outlined the roles of both the public and private sectors in providing health services (Section 52 of the 1997 Constitution of Thailand).

In addition to these political changes the situation regarding the healthcare system in Thailand underwent developments at around this time. These developments slowly evolved over the years and involved external factors (see above) as well as domestic issues.

#### **2.3.2.1 The historical context of the UC scheme**

According to MoPH (2005), the development of the Thai healthcare system prior to the establishment of the UC scheme can be divided into three phrases: firstly, the system that existed before state-provided healthcare became available, secondly, the initial phase of state-provided healthcare between 1963 and 1982 and thirdly, the period between 1983 and 1994, when a wider section of the population was given access to state provision through health insurance schemes. These three phases are discussed in greater detail below.

Firstly, before formal state-provided healthcare was created, people accessed informal healthcare services, such as by taking medicinal herbs and visiting traditional healers and the like, both of which have been used in the treatment of illness since the Sukhothai period (1238 - 1438), when Thailand first became a nation state<sup>13</sup>. Western medicine was introduced during the period of King Rama III in 1828, since when it has played a significant role in society. However, many Thai people still opt to use traditional herbal medicines as part of their tradition, culture, and lifestyle (MoPH, 2005). During the twentieth century, the healthcare infrastructure was expanded by the

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<sup>13</sup> Thailand is now in the period of Ratanakosin under King Rama IX. This period started from King Rama I (1782 onwards).



state and the MoPH was established in 1942. An important development of this period was that the government encouraged health workers to implement a discretionary exemption mechanism for the poor (MoPH 2005, Jongudomsuk 2004a). The most significant growth in state-provided healthcare took place from 1963-1982. Government employees and their dependents were the first group provided with medical care coverage and this was followed by a workmen's compensation fund and system that provided free medical care for the poor. People on low incomes were also given the opportunity to purchase subsidised health insurance in 1981 (see Table 2.1) (Jongudomsuk (2004a).

Table 2.1 State-Provided Healthcare: 1963-1982

Year	Event
1963	Government employees and their dependents were provided with medical care coverage
1967	Life insurance law and an insurance against risk
1973	Workmen Compensation Fund
1975	Free medical care for the poor
1978	First private health insurance
1980	Establishment of the Civil Servants Medical Benefit Scheme (CSMBS) by Royal Decree
1981	Introduction of the Low Income Card

Source: Summarised from Jongudomsuk (2004a)

State-provided healthcare continued to expand during the period 1983 to 1994, when more people were given the opportunity to participate through buying health insurance, through different schemes: the Maternal and Child Health Fund, the Health Card Project (phase II), the Social Security Act (1990), and the Traffic Accident Victim Protection Insurance. Some free health provision was made available: the Health Card for community leaders (including religious leaders) and health volunteers, and the Medical Welfare Scheme for the poor, older people (60 years old and above), children (12 years old and under), and people with disabilities (see Table 2.2) (Jongudomsuk 2004a).

Table 2.2 State-Provided Healthcare 1983-1994

Year	Event
1983	Maternal and Child Health Fund
1984	Health Card Project (phase II) (the low income card was introduced in 1981)
1990	Social Security Act (applied to enterprises with over 20 employees)
1991	Health Card Project (phase III)
1993	Traffic Accident Victim Protection Insurance
1994	Social Security Act (enterprises with over 10 employees)
1994	Free Health Card extended to community leaders and health volunteers (full government subsidy)
1994	Medical Welfare Scheme, extension of free medical care for the poor, elderly (60 years old and above), children (12 years old and under), religious leaders and people with disabilities

Source: Summarised from Jongudomsuk (2004a)

### 2.3.2.2 The socio-economic and political context of the UC scheme

#### Recent political developments

The political upheavals stemming from the period known as ‘Black May’<sup>14</sup>, in 1992, led to many reforms across civil society in Thailand. In particular, there were strong pressures for healthcare changes. During the previous two decades, politicians from the business classes increased their political power under the parliamentary system (Phongpaichit and Baker, 1995). However, these politicians, who were involved in what was termed ‘business politics’, were seen as corrupt, because of their vote buying and bribery practices and this led to a military coup in May 1992. However, this coup was defeated by a middle class alliance once the military had dealt with the corrupt politicians and this led to full democratisation throughout the country (Wongkogathep, *et al.* 2004).

The middle class’s participation in politics during the Black May event allowed more people to take part in the re-drafting of the constitution in 1997, in which healthcare provision appeared under the ‘Rights and Liberties of the Thai People’ (Chapter 3, Section 52) and the ‘Directive Principles of Fundamental State Policies’ (Chapter 5, Section 82). Section 52 of the Constitution (1997) stated that:

<sup>14</sup> Black May is the term given to the period when people protested against the military government in May 1992. About 100,000 people participated in this protest and many were killed and injured in the military crackdown. It is also known as ‘Bloody May’.

‘All Thai people have an equal right to receive standard public health services, and the indigent shall have the right to receive free medical treatment from public health facilities of the state, as provided by laws.’

In addition it stated:

‘It is the fundamental responsibility of the government to thoroughly provide and promote standard and efficient public health services.’ (Section 82)

The subject of equality has become increasingly important in society. According to the new constitution, access to health services was a right. Wongkogathep *et al.* (2004) argued that the 1997 Constitution provided the mechanism for political reform, and during the late 1990s, Thai citizens increasingly engaged and participated in politics in order to create a better society and to push for an efficient and effective health system. The constitution provided greater opportunities for people to participate in the formulation of national policies. For instance, people could propose draft legislation if they could get 50,000 signatures on a petition.

### **The 1992 health reforms**

The health system reforms of 1992 were a part of the overall reform brought about as a result of the 1992 political crisis. The reforms were promulgated by powerful social groups that wanted to bring about an effective health system to work towards resolving the problem of inequity that had long existed. The health reforms were jointly worked on by government and independent agencies.

According to MoPH (2005) the government’s health sector reforms were effective in five main areas.

1. The roles, functions and structures of the public sector and required a thorough review with regards to what the public sector should have been doing. The aim was to reshape the public sector to become ‘results-oriented’ and more responsive to the public.

2. The budgetary and management systems. A new system provided performance indicators and performance reporting systems by relying on the extensive use of information technology.
3. Human resources in the public sector. Competent public officials were sought out in order to provide sound policies and management across the sustainable development and competitiveness of the country. They needed to be customer and results-oriented.
4. Legal reforms. Outdated rules and regulations were reformulated in order for provision to be more effective and efficient.
5. The culture and values. The public sector was required to introduce effective mechanisms to diagnose, detect, prevent and combat corruption.

Alongside directly controlled government agencies that worked on improving the healthcare system, there was a more independent branch that originated with the establishment of the Health System Research Institute (HSRI) in 1992. The HSRI was a public agency formed out of the restructuring of the MoPH to take responsibility for research, such as its investigation into healthcare system (Wongkongrathep *et al.* 2004). In 2000, the Health Systems Research Office (HSRO), an independent body within the HSRI, was set up as the secretary's office of the National Health System Reform Commission. Its main task was to prepare a draft of the National Health Act (2002). Vigorous campaigning and leadership by the HSRO ensured participation from the public and various relevant parties from within the health network in the creation of this piece of legislation.

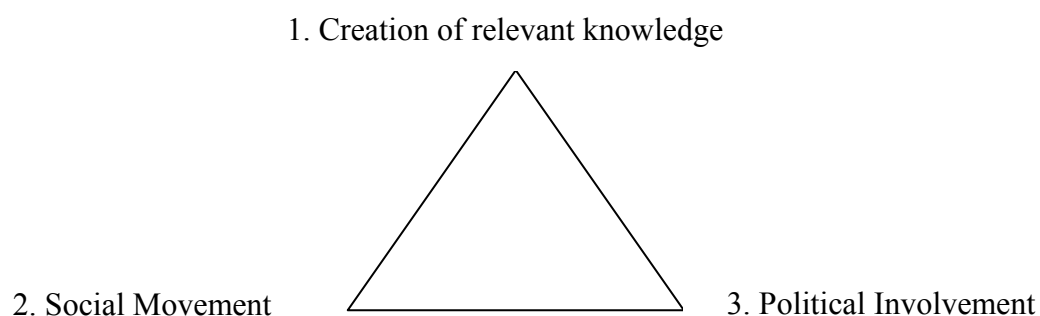
One important development that emerged as a result of the setting up of the HSRI and eventually led to the emergence of the UC scheme was a concept initiated by Dr Pravet Wasi<sup>15</sup> (2000). This uniquely Thai approach to health system reform was known as the strategy of '*Sam Liam Ka Yeon Phu Kao*' or 'A triangle that moves a mountain'. This

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<sup>15</sup> Dr. Pravet Wasi was a public health expert whose contribution in the field included several reforms of the Thai healthcare system. Wasi has been widely recognised as a doctor who dedicated himself to making society, both domestic and international, better. His many accolades comprise the Magsaysay Award in 1957, the WHO Tobacco and Health Award in 1980 and UNESCO's recognition as a distinguished person in the field of educational research and innovation in 1997. In addition, Wasi has held a number of esteemed positions in the field of public health, most notably his position as the Director of the National Steering Committee under MoPH.

strategy comprised three actions: (1) the promotion of learning and raising awareness regarding health issues, (2) the creation of social movements, from the individual to family and social levels, and (3) the design of government policies that corresponded with the first two strategies (see Figure 2.2).

Figure 2.2 A Triangle that Moves The Mountain



Source: Wasi (2006)

Wasi (2000) advocated this approach for the following reasons:

1) In the past there had been severe problems in the health system that needed reform. For example, in the year 2000, Thailand spent 300,000 million Baht on healthcare but only 25% of this came from the government. While health spending had continually increased, there were still a number of health problems requiring attention.

2) Although he recognised that governments have always paid attention to ensuring access to healthcare, inequalities regarding access to healthcare still persisted. He saw a need to create a healthcare system that people could access equally, regardless of their economic wealth (Wasi, 2000). This idea was widely accepted by health administrators and is considered to have been a key factor in the creation of the UC scheme the following year.

### **The Economic Crisis of 1997-1998**

Thailand had a major economic crisis in mid 1997. The crisis affected most of the population, but the biggest impact was on the poorer communities. Many of these people found themselves unemployed after the crisis and unable to avoid slipping into even deeper poverty. People suffered from financial problems and got into debt, which

led to stresses within families and seriously affected the physical as well as mental health of many people. According to Phongpaichit and Baker (2000), there was a rise in the suicide rate, and a rise in the number of orphans as more children were abandoned at hospitals. Children in the Northeast were reported to weigh less and to experience higher rates of malnutrition. The NESDB found that people in general during the era of economic crisis had a higher poverty level, which particularly affected the Northeast (Table 2.3). Furthermore, it was reported that there was greater production and use of drugs. Given these conditions, the number of ill people increased and the burden of health expenses consequently rose, putting more pressure than normal on government health and social services provision (ibid, 2000).

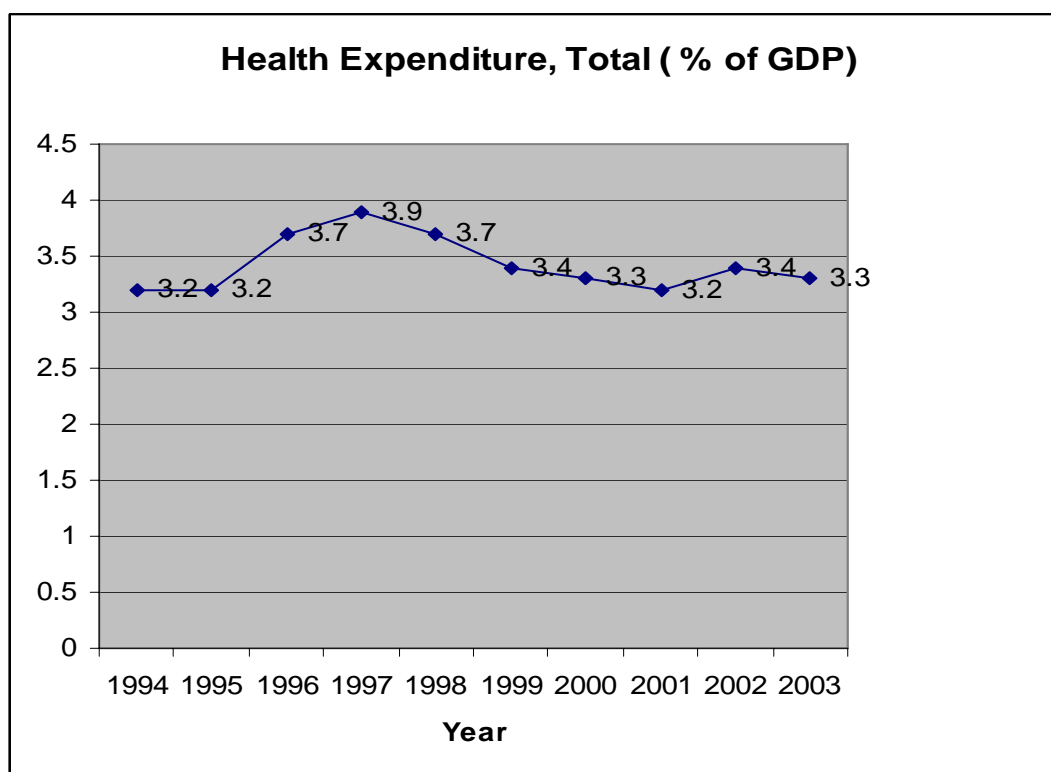
Table 2.3 Poverty Incidence 1988-1999 (% of population living in poverty)

Year	Total	Urban	Semi urban	Rural	Central	North	Northeast	South	Greater Bangkok	< 5 Rai land
1988	36.6	8.0	21.8	40.3	26.6	32.6	48.4	32.5	6.1	67.7
1990	27.2	6.9	18.2	33.8	22.3	23.2	43.1	27.6	3.5	52.9
1992	23.2	3.6	12.7	29.7	13.8	22.6	39.9	19.7	1.9	41.2
1994	16.3	2.4	9.6	21.2	9.2	13.2	28.6	17.3	0.9	28.9
1996	11.4	1.6	5.8	14.9	6.3	11.2	19.4	11.5	0.6	37.2
1998	12.9	1.5	7.2	17.2	7.7	9.0	23.2	14.8	0.6	41.9

NESDB, Indicators 3, (1) January 1999 cited in Phongpaichit and Baker (2000:96)

During this difficult period, the government took a loan from the IMF in order to sustain the country's economic level. In total, Thailand was loaned 16,700 million dollars in aid to improve the economic situation. In addition, the World Bank loaned the government 300 million dollars under the Social Investment Project (SIP) (MoPH, 2005). This budget was used to provide healthcare services to people who were affected by the crisis, such as the unemployed. Despite the fact that the government obtained this financial aid from the World Bank and other organisations to help people who suffered from healthcare problems (MoPH, 2005), it was still necessary for the government to decrease its expenditure on health as part of budgetary cuts. The figures are shown in Chart 2.1 below.

Chart 2.1 Total Health Expenditure (% of GDP) from 1994 to 2003



Source : Adapted from Tangcharoensatien, V. and Waswit, J., 2004

Remark : Data in Year 2002 and 2003 from World Bank (World Development Indicator Database, 2006)

The economic crisis in 1997 led to a decline in spending on health, as a percentage of GDP, from 3.9% in 1997 to 3.7% in 1998, and this continued to decrease until 2001 (HISO, 2004). The budget increased in 2002 due to the government's new healthcare policy on universal health insurance, as illustrated in Chart 2.1 above.

According to Phoolcharoen (2001) the crisis revealed several structural weaknesses in the healthcare system such as poor links between planning, budgeting, ineffective targeting of expenditure on the country's development objectives, lack of fiscal transparency and excessive line-item expenditure controls. The fiscal crisis did not have an adverse impact only on the healthcare system but also on people such as government employees and their dependents, who were entitled to free healthcare service under the CSMBS, had to use a co-payment system instead when they wanted to take up additional benefits and services (NHSO, 2004).

As mentioned in Chapter 1, the economic crisis had led Thailand to change its direction of development to focus more on people rather than only on the economic sector. It was expected that a more holistic approach would create a balance in the development of the economy, society, and the environment, and enable people to achieve increased wellbeing.

### **Populist Politics**

The policy on the UC scheme was created during a period when there were continuous reforms in Thai society. Internal economic factors, pressures from external organisations who were creditors, and from people within the country, led to the emergence of populist politics under the name of the ‘Thai Rak Thai’ (TRT) party, which means ‘Thai loves Thai’. This party led by the former Prime minister Thaksin, with its slogan ‘Think new, Act new’, became the centre of attention and gave new hope to many people who were having financial difficulties.

In September 2000, Dr. Siamwalla of the Thailand Development Research Institute (TDRI) was carrying out a feasibility study into the establishment of the UC scheme. At the same time political parties were campaigning for a general election in 2001 and the TRT party adopted the notion in to their political strategies by calling for a cheap or free healthcare service under the slogan ‘30-Baht treats all diseases’ (Health Systems Research Institute (HSRI) and WHO (2004)). The slogan can be seen in Figure 2.3, which shows a campaign poster in one of the research villages before 2005. This visionary perspective led to the party winning the election and being re-elected in 2005.



Figure 2.3 Thaksin's political poster of the 2005 election



Translation of Thai words: '30-Baht treats all diseases' has created good health for 46 million Thai people and will continue to improve the population's health.

Source: The researcher's own picture

It should be noted that 30-Baht is the equivalent of £0.50 or \$0.86, i.e. a very small sum of money. The slogan that preceded the 30-Baht one was: 'Free Medical Welfare Scheme for People with Low Incomes and Those That Society Should Help' or MWS (in Thai '*Krong Gan Sor Por Row*') for short, and obviously this did not catch the imagination of the Thai people to the same extent as the more modern catchy slogan. However, it was not just the popularity of the slogan that attracted the majority of the Thai population; they were seriously concerned about the inaccessibility of healthcare to the poor. According to Jarasuriya and Hewison (2004), referring to a World Bank report, during the time prior to the economic crisis a large number of private hospitals emerged and when the poor went for treatment they were expected to pay the high prices, but were often unable to. People preferred the private health provision because public hospitals had long queues and were considered to provide inferior services.

The Thaksin government of the Thai Rak Thai party implemented the UC scheme when they were elected in 2001 and it proved to be very popular legislation. This is because it widened access to healthcare, in particular for the poor, and substantially reduced costs,

which for many people were eliminated altogether. Thus, the vast majority of the population benefited from an overall increase in their personal incomes.

There were four major policies that the government utilised to gain popularity.

(1) The 30-Baht scheme; the government spent 110,712.7 million Baht (£ 1,845,211,666 or \$ 2,767,825,000 approx) on this scheme.

(2) The suspended debt scheme; the government suspended the debts of villagers for three years, at a cost of 18,413 million Baht (£ 306,833,333 or \$ 460,325,000 approx)

(3) The village fund scheme; the government launched this programme by giving loans of 1,000,000 Baht to every village in the country in order to boost the local economy and prevent income destitution, at a cost of 74,286 million Baht (£ 1,238,100,000 or \$ 1,857,150,000 approx).

(4) The OTOP (One Tambon - One Product) scheme; this scheme was created in order to decentralise economic opportunities into every sub-district (Tambon) by promoting the goods produced by villagers, at a cost of 800 million Baht (£ 13,333,333 or \$ 20,000,000 approx).

(Changorn, P and Chaitrong, W, 2003)

Of the four major economic policies described above, the 30-Baht, or UC scheme, was the one that ranked top, in terms of the amount of funding. These policies, including the UC scheme, have been criticised by the opposition parties, academics, NGOs and journalists as ‘populist policies’, that place money above everything else (Eaewsriwong, 2003a; 2003b; Siamwalla, 2002; Boonma, 2003; Baker and Phongpaichit, 2004 and 2005). For example, it was found in an assessment of government policies from 2001 to 2003 that people had on average experienced an increase of 11% in revenues, but 22.3% of this had been spent on unnecessary products, which resulted in higher debt (The University of Thai Chamber of Commerce, 2004, cited in Krungthep Turakij, 2004). In addition, Dr. Boonma, a former senior economist of the World Bank, pointed out that providing opportunity for people to have more money is a good idea, but that it is essential to consider whether it is appropriate. In other words, it is important to take into consideration whether people’s spending behaviour is mature enough. As a consequence, academics and economists like Dr. Boonma have expressed concern that conspicuous consumption may push the Thai economy towards recession, as has

happened in a number of Latin American countries (Boonma, 2003). As a result of these potential threats to the economy from over consumption, many academics have proposed that the government should stop employing popular policies to attract votes in a way that might destabilise the country (Krungthep Turakij, 2004). In addition, it has been claimed that the UC scheme is a politically motivated policy rather than a healthcare policy. It has also been argued that these ‘populist policies’ were used by the Thai Rak Thai party as a major campaign to win votes within a short period of time, rather than through taking into account people’s long-term welfare. Not only were the political motivations behind the policy questioned but the scheme was also accused of being over ambitious. For example, the UC scheme was described in a well-known English-language newspaper, the Bangkok Post, as ‘the most ambitious universal healthcare system ever attempted anywhere in the world’ (Swartzentruber, 2001).

On the other hand, Jarasuriya and Hewison (2004) disagree with the idea that the policies of Thaksin are populist. They argue that the comparison with the populist politics of Latin America is incorrect, because Thaksin’s policies are strongly influenced by the IMF and the World Bank under the ‘Washington Consensus’. Therefore, the Thai government approach could be termed ‘global populism’ as it contains the specific characteristics identified by Robert, which are described as follows:

‘ personalistic and paternalistic rule, a multi class coalition, a rather ambiguous ideology and an economic project that uses redistributive methods to consolidate political support .’ (Robert, 1995, cited in Jarasuriya and Hewison, 2004:3).

Thaksin remains a divisive character, facing much opposition in Bangkok and the south, but retaining solid support in the rural areas, especially those of northeast and northern Thailand. One major reason for this strong support in the poorer areas was the continuing popularity of the UC scheme. This is supported by the fact that the Thai Rak Thai Party received large numbers of votes from these segments of the population, who presumably realised they would have greater revenues, with lower expenses through having cheap health insurance. This is also shown by the fact that some of the poor from rural sites, for example the poor under the name ‘The Poor Caravan’ (in Thai, Caravan

‘*Khon Jon*’), campaigned in support of the government in 2006, when many were demanding Thaksin’s resignation (Manager, 20 March 2006).

However, eventually Thaksin’s government became heavily criticised for alleged corruption and failing to control the political conflict in the south of Thailand. Despite being elected for a third term of office in April 2006, after the previous parliament was dissolved, Thaksin was soon forced to step down after mass demonstrations. Although he stepped down temporarily by replacing himself with his close assistant, the public were not convinced that he had left the position permanently. So, in September, a month before the planned new election, there was a peaceful coup by the military.

The UC scheme has not only been seen as a ‘populist policy’ but also many have criticised the former government for using the scheme as a ‘hostage’, in the sense that many people were of the opinion that if they did not re-elect Thaksin the scheme would end. As a consequence, after Thaksin was ousted, in an attempt to reduce his popularity, a group of Thai NGOs suggested that the succeeding government should continue supporting the UC scheme (Matichon 2006). Given the widespread support for the scheme, on 31 October 2006, after the fieldwork of this current research had been completed, the new government made the entire UC scheme cards free and tried to distance themselves from the old government by ditching the 30-Baht association, naming the new scheme the Universal Healthcare Project (NHSO, 2006).

The free scheme continues to this day and has been watched from around the world regarding its progress, as it is considered to be a beacon for healthcare provision in emerging developing countries. For example, meetings on health collaborations were organised in neighbouring countries, and Laos and Cambodia have recently been deciding whether to implement a similar scheme (MoPH, 2004).

## **2.4 What is the Universal Health Insurance Coverage (UC) scheme?**

Previously, there were four types of healthcare schemes (Towse *et al.*, 2004) provided for Thai people. There was the Civil Servants Medical Benefit Scheme (CSMBS) for civil servants and their dependents. The second scheme is the Medical Welfare Scheme (MWS) which provided free care for low-income families, poorer individuals, the elderly, children under 12 years old, people with disabilities, monks, community

leaders, health volunteers and their families. The third type comprised a voluntary healthcare scheme ie. the government health card scheme which cost 500 Baht (approx £8) a year with free access to all healthcare services, and private health insurance protection (voluntary risk-related premium contributions) which covered mainly the better off. The last type consisted of compulsory social insurance programmes, ie. the Social Security Scheme (SSS) for the employees of private firms, which employ 10 or more people , and the road traffic accident insurance coverage, through premiums paid by all car and motorcycle drivers to their private insurance firms. However, in 2000, only 44.37 million people were covered under these four schemes. The other 18.5 million of the population, approximately 31%, paid fees for other public or private healthcare services (Jirojjanakul *et al.*, 2004).

The UC was formed through a merger of some of the types of coverage listed above, i.e. the second (the MWS) and third (the 500 Baht government health card scheme) and included the 18.5 million people who were previously uninsured. Those who were formerly on the second scheme were transferred for the UC free card whilst those who were using the third scheme now paid 30 Baht per visit to a healthcare provider, instead of 500 Baht per year. The merging of the schemes is illustrated in Table 2.4.

Table 2.4 The merging of previous schemes into a Universal Health Insurance Coverage (UC) Scheme

Before UC	After UC
1. Civil Servants and dependents : <u>Free</u>	1. <u>Remained Unchanged</u>
2. Low income card scheme: <u>Free</u>	2. Mostly transferred to free card
3. Voluntary healthcare insurance : <u>500 Baht /year</u>	3. Before coup - Mostly transferred to Co-payment card (30 Baht)
4. Uninsured people: Pay themselves	4. Covered by the UC card
5. Workers in private firms : <u>Social Security Scheme</u>	5. <u>Remained Unchanged</u>

Note: All UC card after the 2006 coup transferred to free card.

Although the scheme was introduced in 2001, the relevant act, the National Health Act, was passed by Parliament in November 2002 (but not formally announced until 2007) according to the National Health Commission Office of Thailand (NHCO) 2009. As a result, the National Health Security Office (NHSO) was created one year later to regulate the quality and financial elements of the scheme. The emergence of the NHSO can be considered as ‘an innovation’ of the major healthcare reforms, as it has also

changed the financial management system of healthcare (NHSO, 2004). This is because prior to the UC scheme, the Ministry of Public Health (MoPH) principally assumed both purchasing and service provision. However, since the UC scheme has been in operation, according to Hughes and Leethongdee (2007), the purchaser – provider system has been adopted. This system is based on the separation of purchaser and provider. The MoPH has become the major provider and the NHSO constitutes the main body that purchases services on behalf of the public, channelling budgets through a system of Contracting Units of Primary Cares (CUPs). In addition to the purchaser – provider system, ‘the capitation contract model’ was also introduced (Tangcharoensatien *et al.*, 2004). The capitation contract model, according to Tangcharoensatien *et al.*, 2004, is a financial system through which hospitals receive a fixed, per capita yearly payment in exchange for agreeing to provide a specified set of services to patients. Although this system in theory should enhance competition among service providers, which would in turn give the public greater access to higher quality healthcare services, in reality the PCUs in local areas and small rural hospitals suffer under this system. For example, Leethongdee (2007) finds that small rural hospitals did not directly receive the full amount of funding allocated by the government. The recipients are the main contractors at the higher levels of health administration. The implementation process of the UC scheme and health system reforms are widely discussed within healthcare research<sup>16</sup> in Thailand (see for example Leethongdee, 2007; Pitayarangsarit, 2004; Wichaikhun, 2004) and will not be discussed in this thesis. Discussion in this thesis will focus mainly on the service users (i.e. the villagers) from the social dimension of wellbeing.

In summary, the UC is a health insurance scheme paid for by the government, which initially was provided in two forms: free and co-payment. The co-payment card required the owners to pay 30 Baht per hospital visit, whereas, by definition, those with a free card did not have to pay. As stated above, on 31 October 2006 all scheme participants were given free cards. The UC ID cards are commonly known as gold cards.

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<sup>16</sup> The work of Leethongdee, 2007; Pitayarangsarit, 2004; and Wichaikhun, 2004 offer some insights into the implementation of the UC scheme from more of a health dimension.

### ***2.4.1 Benefit packages under the UC scheme***

The benefit packages available under this scheme are slightly different from those under other health schemes (CSMBS and SSS). Services include curative care, rehabilitation, health promotion, prevention care and accident as well as emergency care. Curative care in the scheme consists of examination, diagnosis and medical rehabilitation whilst prevention and promotion services include vaccinations, family planning, antenatal care, dental preventive treatment and anti-retroviral drugs for HIV/AIDs patients. The scheme aims to provide the opportunity for all to have access to basic healthcare at a low cost.

At the start of the scheme, anti-retroviral drugs for HIV/AIDs patients were actually excluded, owing to their expense, as were treatments for kidney failure. Pressure from NGOs and networks for people living with HIV/AIDS were successful in changing this in late 2001 (Agence France Presse (AFP) 2001) and anti-HIV/AIDS drugs for the prevention of disease transmission from mother to child were included in the coverage.

For some there remain limitations. For instance, there is no access to renal dialysis services<sup>17</sup>, which in contrast are provided for civil servants and those covered by social security scheme. The UC scheme does not cover the following services: a) drug addiction therapy and rehabilitation, b) injuries sustained from car accidents under third party liability insurance, c) assisted reproduction for infertility, d) in vitro fertilisation, e) sex change operations f) any surgery for beauty enhancement without medical necessity, g) admission as an in patient for more than 108 days, for the same disease, except in the case of complications, h) research or experimental curative care, i) peritoneal dialysis and haemodialysis for chronic renal failure, j) HIV antiviral medications, except for the prevention of disease transmission from mother to child, k) organ transplant and l) mental health patients who have been an in-patient for more than 15 days (NHSO 2004). For additional details about the benefit package see Appendix 1.

Moreover, people cannot use the UC card wherever they decide or prefer to be treated, but rather they have to register with the government healthcare network, according to

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<sup>17</sup> Last year (2008), the government announced that patients under the UC were able to use renal dialysis services.

their residential location. In this way the local healthcare centre is used for primary care and a nearby hospital is used for secondary care. Patients who do not use the healthcare network are obliged to cover the cost of treatment themselves.

### **2.4.2 The Purposes of the UC**

The government created the UC in order to ensure that all people enjoyed equal access to high quality healthcare services. Purposes of the scheme have been listed as follows.

- **Equity:** Promoting equity in constitutional legitimacy and access to the same standard of services.
- **Efficiency:** Facilitating efficient healthcare services.
- **Choice:** Offering an alternative choice for people in order to reduce the problem of an imperfectly competitive market.
- **Good health for all:** Acting as an insurance policy as well as a personal healthcare system. In addition, it aims not only to provide curative care but also to provide disease prevention and health promotion where appropriate.

(Sreshthaputra and Indraratna, 2001).

Improved access to healthcare is considered to be a central objective of the creation of this UC scheme that was founded on the basis of universal health insurance for all citizens. The UC scheme has attempted to improve access to healthcare by providing services at prices that are lower than before or even free by making the services more convenient to reach. Raising standards and improving efficiency in the healthcare service system through a range of measures are summarised as follows:

- Providing extremely low-priced medical services (at 30 Baht per treatment<sup>18</sup>)
- Designing inclusive services or benefit packages which cover illness preventions, medical treatments and recoveries with the aim of creating a healthcare system that responds to the citizens' health problems.

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<sup>18</sup> Free services provided since October 2006.



- Encouraging people to register for healthcare services at local medical venues according to their geographical area (maximum 30 minutes journey time). This is to ensure that they have easy access and more convenient services.
- Allocating resources per head of population so that a larger amount of budget is given to more populated areas in which there exists higher demand for healthcare, thus making the provision more effectively targeted.
- Improving standards of various services in order to ensure that people get access to the same standard of quality services, eg the quality of hospitals needs to be certified based on the principles of Hospital Accreditation (HA).

(Health System Research Institute (HSRI) and WHO 2004)

The UC is underpinned by the principle that everybody, regardless of their financial status, can be provided with the same quality of public health service by having health insurance. Health insurance is the financial mechanism that ensures that the sick receive the treatment that they need regardless of their ability to pay and that the well-off, who can afford to pay for insurance, contribute to the services for the unwell. Moreover, at the individual level insurance helps to protect people from economic hardship and uncertainty with regards to unpredictable and uncontrollable bouts of ill health. In addition to this, at the societal level the government or provider of the universal scheme can distribute resources to the various health institutions according to need. That is, health insurance represents a way of distributing healthcare expenses among groups of people with different levels of risk. It effectively transfers the purchasing power from healthy people to those who are ill and ensures that those who have health insurance can acquire health services without having to worry about the expense (Jongudomsuk, 2003). Aiming to make sure that nobody would be prevented from receiving such services because of financial problems, the government, in effect, subsidises healthcare.

### ***2.4.3 Recent debate on the UC***

There have been various debates concerning the impact of the UC. Positive and negative criticisms have come from both the service providers and the service users.

### 2.4.3.1 Positive views

There have been several studies which suggest that the UC scheme has had a positive impact on healthcare access.

The Health System Research Institute (HSRI) and the WHO (2004), as well as the Ministry of Public Health (MoPH, 2004) revealed that more than 70% of people benefit from the UC scheme. People of working age have taken the highest number of UC cards, reflecting the country's age structure in which people of working age form the majority of the population. However, significant numbers of the young and the elderly have also taken up the card.

When considering gender, a study conducted by the HSRI and WHO (2004) suggested that slightly more women than men were registered to use health cards in 2002: 52.1% versus 47.9% for the 30-Baht card, and 51.9% versus 48.1% for the free gold cards. On the other hand, a contrasting picture was revealed by the research of the NHSO, which showed that in 2003, more men than women had registered for UC cards: 55.74% of men versus 44.26% of women (Jongudomsuk, 2003).

The UC received positive feedback from the ABAC opinion poll that surveyed users (people) and service providers (health workers). Two examples of the ABAC Poll can be assessed: 2003 and 2005<sup>19</sup>. The results in 2003 showed that 6087 service users rated the scheme at 8 out of 10, whereas the service providers ranked it at 6.15. In the survey in 2005, 6294 users still rated the scheme highly, and gave the scheme 7.83 out of 10, while the providers rated it at 6.14. Results showed that on average more than 90% of people sampled were satisfied with all aspects of the provision (across 9 dimensions). One main reason for people's satisfaction is that the UC scheme helped them to reduce their healthcare expenses (ABAC poll 2005; The Public Health Commission 2002). A NHSO report carried out between 2002 and 2004 investigated the changes that had occurred since the establishment of the UC scheme. A summary of their findings is presented in Table 2.5.

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<sup>19</sup> An important part of the survey asked about user satisfaction with the 30-baht scheme based on 9 dimensions of the UC scheme: 1) quality of doctor's service, 2) nurses and their assistants, 3) other members of staff 4), quality of medicines, 5) medical appliances, 6) convenience of the service, 7) making appointments, 8) easy to access in terms of travelling and 9) treatment outcomes.

Table 2.5 Summary of the findings of the UC project: 2002-2004

Before the project	Present (2005)
20 million Thai people did not have health insurance.	All Thai people have health insurance.
Healthcare expenditure by the rich was 6.4 times that by the poor.	Healthcare expenditure by the rich is only 1.6 times that by the poor.
2.8 million people were in debt and became bankrupt due to health problems.	More than one million people receive help.
The poor suffered from heart disease due to neglected health problems.	More than 8,832 patients have had heart operations.
A large number of elderly people had sight problems as a result of cataracts.	More than 15,000 patients have received phacoemulsifications (removal of a cataract by emulsifying the lens ultrasonically).
Poor people suffered from untreated cancer due to the lack of money for treatment.	199,243 patients have received chemo and radiation therapies
Access to healthcare services was difficult.	Access to healthcare services easier (more than 120 million users per year).

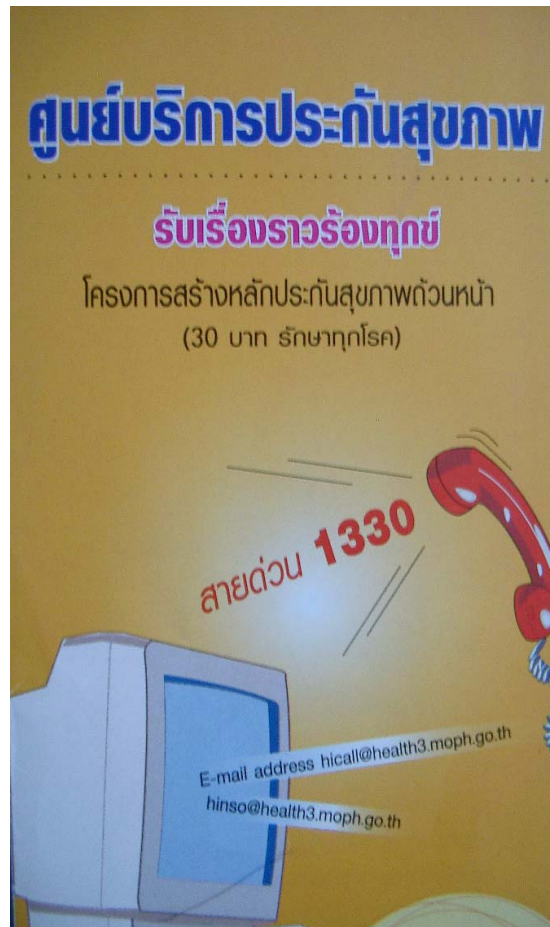
Source: The National Health Security Office (NHSO) 2005

In more general terms, the National Statistical Office of Thailand (TNSO) has surveyed people's levels of satisfaction with the national government across 13 elements of performance. In 2004, they found that people were highly satisfied with the issue of public health, putting it ahead of sport and education, the figures being 78.3%, 77.1% and 76.4%, respectively (The National Statistical Office Of Thailand (TNSO) 2004). This study also surveyed people's attitudes towards their social conditions, which allowed for a comparison between different regions of the country. The results showed that most people in the northeast felt that social conditions had improved (71.7%) as compared with those in the north and the centre (65.3% and 51.4%, respectively). However, 46.2% of people in the south did not perceive that there had been any improvements in terms of social conditions, whilst 44.5% agreed that they had improved. These findings could be explained by the fact that people in the northeast, who make up the majority of the Thai population, and have a tendency to be among the poorest, had benefited most from the various government projects, including the UC policy.

Most importantly, from following news and events in relation to the UC scheme, many actions have been taken by different governments to improve the UC scheme since 2001.

The first example is the creation of various strategies at the early stage of the introduction of the UC scheme, to increase patients' access to information and confidence in using the UC service. For instance, call centres (see Figure 2.4), 'complaints boxes', and 'extra services' such as ambulances, were provided for the users and some hospitals.

Figure 2.4 An example of a leaflet of the 30 Baht scheme



Transplantation of Thai words: Centre for Health Insurance Service accept complaints regarding the 30 Baht scheme, Hotline 1330.

Source: Ministry of Public Health 2004

The second example is a prompt response to problems with the UC scheme. In 2001, there was a problem in that People Living With HIV and AIDS (PLWHA) were excluded from the scheme. However, the government included all PLWHA in the 30-Baht scheme in 2002.

The third example is the enhanced rights of the UC scheme users. The patients' rights were established under the National Health Act (NHA) and through this they are entitled to compensation in cases of medical malpractice, according to the NHA Sections 41 and 42, as was widely explained in a television campaign.

The fourth example is the application of Hospital Accreditation (HA) in 2003. The HA system has been used to improve the quality of services provided under the UC scheme in hospitals all over the country, in order to ensure the quality of the UC scheme and maintenance of its standards.

The fifth example is the change of the slogan in 2005. In order to emphasise health promotion and prevention rather than cure, the slogan of the UC, which was formerly known as '30-Baht treats all diseases, was changed to '30-Baht helps Thai people to stay away from diseases'.

The sixth example is the elimination of the rule regarding emergencies. In 2007, the government made an official announcement that they were abolishing the rule that in emergencies people would only be allowed two opportunities to utilise healthcare services in medical establishments they were not registered with, which was particularly limiting for migrants. As a consequence, patients are now able to acquire emergency medical care from other establishments, according to their needs.

The seventh example is the inclusion of renal dialysis services. Patients needing kidney dialysis can now receive this under the scheme, as was set out in 2008.

The final example, and the most recent important development in 2009, is a gender sensitive solution, known as 'miracle underwear'. This has been devised to tackle the problem of women feeling embarrassed if they are asked to take their clothes off, which previously was a barrier to them having cervical smear tests.

### **2.4.3.2 Negative views**

Although the UC has provided better access to healthcare at lower costs to the users, it has been argued that the UC has created more problems for healthcare workers and the healthcare system as a whole. Drawing on the result of the ABAC public opinion poll highlighted above, the NHSO's annual report noted that it appeared that 67% of users were satisfied with the UC scheme, but 47% wanted some improvements to be made in the quality of the service, 37 % did not trust the quality of services when compared with the other governmental schemes (Jongudomsuk, 2003). The ABAC poll in 2005 revealed that 36.7% of users had experienced difficulty with the service and had thought about complaining. However, only 1% had actually made complaints according to the data (ABAC poll, 2005).

The main criticisms of the scheme are summarised below.

#### **1) Patients cannot choose where they access healthcare**

The conditions of the UC state that people must register with the government healthcare network according to their residency and cannot choose the place where they receive healthcare services. Although they are aware of the differences in the quality of each hospital or health provider, they have to attend the institutions which are identified in the card. Otherwise, they have to pay for the service. In 2004, a monitoring report of the UC scheme Phase 1, conducted by the HSRO, found that most respondents did not agree with the regulation that people had to utilise services only at the healthcare providers with which they were registered (HSRO, 2004). According to the Jongudomsuk, (2003) 17.9% of users wanted to make their own choice regarding the service centre at which they were to be treated. Moreover, 16.2% of users felt that the healthcare provision for which they had been registered was inadequate. The criticisms were that services lacked experienced doctors, used poor quality medicines, and had very lengthy waiting times (National Statistical Office of Thailand (TNSO) 2003).

#### **2) Insufficiency of staff and equipment in Primary Care Units (PCUs)**

The UC scheme has aimed to improve the standard of healthcare given to users through developing the network of Primary Care Units (PCUs). However, most primary care has not maintained a good enough quality of care, owing to lack of facilities and human

resources. In particular, there is a lack of physicians for PCUs in most rural provinces, owing to physicians being unwilling to work in these areas. Moreover, poor staff distribution and lack of resources has further reduced the quality of treatment in PCUs. For these reasons, it has been reported that the majority of people prefer to use their UC card at hospitals rather than at PCUs (Jongudomsuk, 2003).

### 3) The increase in workload for healthcare providers

The increasing demand for hospital services has meant more responsibility for the staff, which in turn has created a higher workload for doctors. This has apparently adversely demotivated healthcare professionals. Moreover, according to the National Health Act (Sections 41 and 42), patients may claim compensation if the treatment is poor and blame is found. This has had the effect of discouraging the treatment of patients with serious illness, which as a consequence may have caused further inconvenience to patients who have had to seek out alternative care and pay out more (The Public Health Commission, 2002). In 2004, there were 468 resignations by doctor and the number increased to 663, 777 and 785 in 2005, 2006 and 2007, respectively (MoPH 2008).

The ABAC poll (2003) also found that 74.4% of service providers felt that they were faced with a higher workload under the UC scheme than before. The reasons given for this were an uncertain and constantly changing system of financial and budgeting management, since the government scheme was rapidly implemented without any local preparations. The effect of the increased workload has been to reduce the time spent in diagnosing patients, which may have impacted on care standards. In 2003, only 3.9% of hospitals received quality accreditations, according to the Hospital Accreditation system (HA) (Jongudomsuk, 2003). As a result, 18.7% of users complained about the quality of service (ABAC poll, 2005).

### 4. Inequitable treatment, access and outcome

Although the National Health Security Act allows for the CSMBS and SSS to be merged into a single universal coverage scheme by decree, this issue remains politically controversial and has faced objections from many relevant parties (Mills *et al.*, 2005, cited in Pannarunothai, 2008). This has led to villagers thinking that their provision was inadequate when compared to that available to civil servants, who could use the other governmental schemes. According to Khamleung (2002), 4.3% of people felt that they

were treated inequitably under the scheme. However, it was reported by this researcher that a much larger proportion of people, that is 41.1%, were of the opinion that the rich still had priority for treatment and received better services. Sreamsee *et al.* (2003) confirmed these views when they examined the issue of accessibility and found that people in rural areas still received an unequal level of treatment. This is in line with a report from the Public Health Commission (2002) that disclosed that regional services continued to fail to provide treatment for serious illness such as cancer, heart or brain disease when compared to the work carried out by urban hospitals. People living in rural areas were not able to receive immediate treatment for these complaints because they had to travel to provisions situated in Bangkok. It is also found that many of the poor are unable to access the UC scheme and many of them continue using 'over-the-counter and private medicine' (Camfiled, 2006:22).

#### 5) Volatility in the administration of the UC scheme

The vast reforms in the national health budget have had far reaching impacts on the healthcare system. The most relevant reform was the change to the method of budget allocation, which saw the introduction of the NHSO and 'the capitation contract model' mentioned above. In 2001, the Thai capitation rate was 1200 Baht (approximately £18) and by 2006 this had risen to 1600 Baht (approximately £23). However, Na Ranong *et al.* (2002) conducted an audit on the UC scheme and found that the capitation allowance for the year 2003 was less than for 2002 despite the total budget being higher than in 2002, which indicates that the capitation rate did not increase year on year.

A financial crisis in the UC scheme was reported to have occurred in 2005. A report in a newspaper referred to academic research that had been conducted during 2002 to 2003 by Na Ra Nong. This reportedly found that 900 hospitals under the UC scheme were 900 million Baht over budget even though the capitation allowance had increased from 1500 to 1659 Baht per person. At this time, Dr. Siamwalla of the Thailand Development Research Institute, a prominent Thai economist, suggested that the 30-Baht scheme would collapse unless approximately 30,000 million Baht was injected into the project (Manager, 2006).

Other problems that hindered the effective implementation of the scheme included the following: staff in deprived rural areas lost their motivation to work when doctors resigned or asked for transfers; insufficient staff numbers; and unreliable budget



allocation, all of which affected performance and thus had a direct impact on service users. In addition to this, regarding healthcare information, many groups of people, particularly those in rural areas, did not have access to information through media such as 24 hour call centres and the internet, even though these types of technology were widely available in the towns and cities and this often led to rural people being unaware of their entitlement.

The above negative perspectives about the scheme can be explained by a number of key limitations regarding its method of execution. Firstly, there was limited preparation, owing to the government's rapid implementation of the scheme, because it had been an election promise in 2001. The scheme was first launched in 6 provinces in the three months following the general election, and later expanded throughout the 76 provinces in the remaining nine months of the same year. This rapid change led to serious pressures being put on the health infrastructure and healthcare workers. Secondly, the public had high hopes of the new government and of the scheme, which, as stated above, was rolled out under the campaign slogan of '30-Baht treats all diseases'. This may have had the effect of creating unrealistic popular expectations and hence resulted in people being especially critical of the results. Thirdly, as explained above, there have been many changes in Thailand regarding health provision over the last few decades and health workers have been expected to incorporate these changes into their work practice. When the UC scheme was introduced, some of these health workers were cynical as to whether it would work and did not apply themselves to the new system.

## **2.5 Conclusion**

This chapter has discussed the emergence of the UC scheme in Thailand. Firstly, the underlying determinants of health were discussed, with a particular focus on the importance of good health and access to appropriate healthcare. This was followed by a consideration of health inequality and the inequitous distribution of healthcare facilities among the Thai population. The reasons for these differences were then addressed in the contexts of location, gender, age and class. Subsequently, there was a detailed presentation of the political and socio-economic background, both international and domestic, that led to the establishment of the UC scheme, and the events that happened during its first years of implementation. The final part explained the content and workings of the UC scheme and concluded with a discussion on the pros and cons of the

scheme from the point of view of academics, politicians, the media, healthcare workers and the population in general through opinion polls.

The following theoretical chapter contains the literature review, which considers healthcare evaluation approaches and discussions on the validity of applying wellbeing as an evaluation tool. Subsequently, a new approach to evaluation to be applied in this research, in the context of health and wellbeing, is introduced, and so too are the research questions.

### **Chapter 3: From a narrow healthcare evaluation to a wellbeing assessment**

The previous chapter has provided an extensive description of the development and structure of the UC scheme, this chapter reviews different approaches to evaluating the provision of national healthcare systems in general and in the Thai context specifically. It argues that most current evaluations of the UC scheme in Thailand are inadequate, whether conducted by academics, polling organisations or government agencies, because they adopt narrow evaluation criteria. It is argued that this singular emphasis on quantitative and objective criteria is inadequate as this narrow analysis not only fails to take account of the socio-economic and political transitions that have occurred in Thai society, but it also ignores the significance of the wellbeing focus which has become the policy goal of health promotion and healthcare in Thailand. An important and innovative feature of the wellbeing focus is that it emphasises people's perceptions and experiences. This is also crucially missing from conventional evaluation approaches, although attempts to capture it have been made through assessments of satisfaction WHO Quality of Life (WHOQOL) measure of Health-Related Quality of life (HRQoL).

The aim of this chapter is to put forward a new approach using a multi-methods approach, which employs both qualitative and quantitative methods and is sensitive to different factors in evaluating healthcare in Thailand. It proposes a broader method for UC scheme evaluation by adopting a wellbeing approach which allows for an appreciation of the interaction of different gender, age and class attributes, as well as an exploration of people's subjective evaluation of healthcare.

This chapter is divided into three sections. It begins with a review of conventional healthcare evaluation approaches in general and existing evaluations of the UC project in Thailand. The second part discusses the concept of wellbeing in relation to health and healthcare, which starts with an international perspective and then focus on Thailand. The last section draws on the description of the UC scheme in pages 67 to 69 to outline the methodology that has been developed to evaluate the scheme. It concludes by proposing a new approach to evaluation of the UC scheme: a 'wellbeing-focused evaluation'.

## **3.1 Conventional Healthcare Evaluation Approaches**

### ***3.1.1 Healthcare evaluation in general***

Providing all people with equal access to basic healthcare services is one of the fundamental challenges faced by governments worldwide. This problem is critical in developing countries where health systems' administrators struggle with scarce resources.

As a result of limited resources for healthcare worldwide, health interventions need to be assessed for their effectiveness in order to decide which should be continued or improved upon. An effective evaluation method is an important mechanism for making operational decisions about healthcare and informing policy choices, but evaluating the impact of a healthcare scheme is a challenging task. Two main types of problems associated with evaluation are: methodological problems and the intrinsically political nature of the provision of a healthcare system and of healthcare reform (Figueras *et al.*, 1997; Klein 1998)

There are different methods for healthcare evaluation; however, the decision on what is a suitable technique is difficult as the choice of method depends on several factors. For instance, the reasons for the evaluation, the interests of the sponsor of the evaluation, and the different backgrounds of evaluators must all be taken into account (Balaban and Goldfarb 1983). This chapter will review the main forms of evaluation which are used in both developed and developing countries and these are introduced below.

According to Evans *et al.* (2001), measuring the quality of the healthcare system should focus more on outcomes than on processes. He argues that because outcomes depend on the correct functioning of the different levels of the whole system there is no need for a separate measure of process. Evans proposes that healthcare system evaluation be based on the WHO framework (2000), which highlights three main goals for healthcare:

1. To improve people's health;
2. To respond to patient need (respect for people and client orientation); and
3. Fairness in financing.

These three goals can be linked to five different healthcare evaluation approaches. The first goal, i.e. ‘to improve people’s health’, emphasises the improvement of physical and mental health and is the basis of two main evaluation approaches. The medical evaluation approach is based on clinical measures while the Health-Related Quality of Life Approach (HRQoL) focuses on both self-reported health (e.g. symptoms) and the subjective health perceptions of patients.

The second goal, on the other hand, focuses on another aspect of healthcare outcomes: the interaction of individuals with the health system, or the relational aspect. This has two components: respect for the person and ‘client orientation’. The former involves ethical dimensions such as people’s need as human beings for respect, dignity, and autonomy whilst the latter includes the components of consumer satisfaction, for instance prompt attention, provision of basic facilities, access to social support networks i.e. presence of friends and relatives during treatment, generous visiting times. This method measures patients’ satisfaction, which is related to the importance of understanding the patients’ point of view.

The third goal, fairness in financing, operates both at the individual and national level. Economic evaluations such as Cost Effective Analysis (CEA), Cost-Utility Analysis (CUA) and Cost-Benefit Analysis (CBA) are proposed to assess the quality of the healthcare system, acknowledging the limitations of government budgets. Financial risk protection for households is also important; for example a household’s contribution to the healthcare system should not systematically weaken its members economically during a sudden illness. In addition, poor households should spend a lower proportion of their disposable income on health than rich households. In this respect, evaluations based on the concept of equity are used in order to make effective healthcare available among groups or individuals in an equitable way.

There are many healthcare systems in the world and thus healthcare evaluations are practiced in a wide variety of ways. In order to develop a healthcare policy that achieves better results, evaluators need to know how healthcare policy can be measured. Despite the fact that evaluators use various methods to evaluate whole systems of healthcare and sometimes these methods overlap, it is necessary to explain each method separately. The following section reviews the main healthcare evaluation approaches

(clinical, quality of life, patient satisfaction, economic, and equity based), according to Smith *et al.* 2005, and considers how they address the three main goals.

### 3.1.1.1 The Medical Evaluation Approach

The first approach is related to medical science and is commonly known as ‘the medical evaluation approach.’ This approach concerns itself with the objective health of patients which is evaluated through physical and mental health assessment. It focuses on the health evidence of patients at an individual level by looking at clinical signs (e.g. blood pressure, temperature, X-ray) and at the population level (e.g. mortality and morbidity rates). It also uses standard medical diagnostic criteria such as the International Statistical Classification of Disease and Related Conditions (ICD) to determine the success of health care systems (Smith *et al.* 2005).

Healthcare evaluations using this approach are based on clinical measures or indicators defined by doctors, which presumes that improvements in health are measurable at the level of physiology and primarily attributable to improvements in healthcare. For example, Shortell and Richardson (1978) state that hospital based group practices or immunisation outreach efforts have been a major component in improving healthcare. Examples of medical approaches are given by Boon *et al.* (2006) and include 1) complex intervention research which is a framework developed by the UK Medical Research Council (MRC); 2) Whole Systems Research (WSR) developed by an international group of researchers in Canada; 3) whole medical systems research developed by the USA National Centre for Complementary and Alternative Medicine (NCCAM); and 4) a Complementary and Alternative Medicine (CAM) model developed in Norway. The gold standard for evidence is still the pharmacological Randomised Controlled Trial (RCT) <sup>20</sup> model. Although there may be ethical, epistemological, and practical reasons for adopting these, Boon *et al.* (2006) raised the issue that RCTs alone might not be appropriate in evaluating healthcare systems, which are becoming increasingly complex.

There is a considerable amount of healthcare evaluation research that focuses on specific medical conditions; for example, the approach taken by the National Institute

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<sup>20</sup> The randomised controlled trial (RCT) is a study in which patients are divided to ‘study’ and ‘control’ groups. The study groups receive active treatment but those in the control group do not. Patients are randomly allocated between groups to minimize bias according to age, sex, social class, etc ( Jenkinson and McGee, 1998).

for Health and clinical excellence (e.g. Nelen *et al.* 2006; Miller *et al.* 2006; Konety *et al.* 2006; and Williams *et al.* 2005). These evaluations attempt to measure the effectiveness of medical treatment by including pre and post measurement of clinical outcomes in order to find better outcomes for patients. For example, Nelen *et al.* 2006 used it to monitor reproductive health care, Miller *et al.*, 2006 and Konety *et al.*, 2006 to evaluate the effectiveness of cancer treatments and Williams *et al.*, 2005 to assess the treatment of dementia.

The medical evaluation approach is clearly an important aspect in healthcare because it contributes to and generates confidence in the healing process among patients, which improves outcomes (White 1983). Any improvement of the treatment as a result of carrying out a medical evaluation is thus a benefit to patients as it achieving a higher standard of treatment. It also assists healthcare professionals to avoid harming patients. Although the medical evaluation approach is popular owing to the belief that medical based assessment is valid, there are still criticisms of it.

The major critique of this approach is its sole emphasis on medical dimensions is not adequate for evaluating the whole system of healthcare. This is because health and healthcare systems are related to several factors, not only to what we may crudely refer to as 'the state of the body' but wider issues, such as economic prosperity and social dimensions. Sen (2003) pointed out that longevity is often taken to be a primary success of a good healthcare policy and the focus on longevity is used to indicate a level of human achievement, as seen, for example, in the UN Human Development Index. Sen (2003) further argued that any systematic framework for assessment of healthcare projects must therefore address more dimensions, not merely that of medical excellence. Likewise, Boon *et al.*, (2006) claimed that contemporary healthcare systems around the world are complex. This complexity derives from many components such as: public healthcare, palliative care, integrative medicine, rehabilitative medicine, and interventions within the systems. Consequently, the evaluation of these complex healthcare systems cannot be achieved by using a biomedical model that focuses on single components and assumes a direct relationship between an intervention and its effect. Thus, in practice, applying just this model for healthcare evaluation is limited and in order to evaluate the effectiveness of a complex healthcare system, a broader methodological approach, supported by a new conceptual framework, is needed.

For example, Boon *et al.*, (2006) recommended that multiple methods and integrated programmes of research, undertaken by interdisciplinary teams are required.

### **3.1.1.2 The Health-Related Quality of life Approach (HRQoL)**

The second healthcare evaluation measures health-related quality of life (HRQoL), and is termed the health-related quality of life approach. The HRQoL concept is based on the idea of Quality of Life (QoL) which originated as an area of study in sociology and social policy. Later, QoL was adopted and defined by health sciences and psychology in terms of people's perception of their health status (Schmidt and Bullinger 2007). In this context, HRQoL is considered to be a subjective dimension. In addition, it has a broader concept of health and includes aspects of physical, psychological and social health and thus can be applied in a variety of forms. HRQoL is considered to be more specific than QoL and refers to the impact of a health condition or intervention while QoL involves other influences, such as environmental and socioeconomic factors (Smith *et al.*, 2005).

According to Schmidt and Bullinger (2007) the main HRQoL measures are the Short Form 36 (SF 36), the WHO Quality of Life Group (WHOQOL), the General Health Questionnaire, the Psychological General Wellbeing Index, and the Nottingham Health Profile (NHP). These have been translated and adapted for applying across cultures in Europe, Africa and Asia. The SF 36 in particular is widely used in Asia and the Pacific (Schmidt and Bullinger, 2007). It was created for the purposes of the Medical Outcomes Study in North America during the 1990s and comprises a short survey that covers both mental and physical health. It aims to find out patients' subjective opinions such as their perception of their health (Ware 2007). It was introduced in developed countries and has become increasingly used. According to Ware (2007), the SF 36 has been documented in nearly 4,000 publications and used in 22 nations. In addition there are more than 10 international comparative studies, i.e. studies covering up to 13 countries, that have used this measure (Ware 2007).

Another widespread cross-cultural measure of quality of life for use in health and healthcare is the WHOQOL which is available in 40 countries and in most majority languages (Skevington *et al.*, 2004). The WHOQOL covers measures of physical, psychological, social and spiritual domains of life. It was developed collaboratively in a number of centres, in diverse cultural settings, over several years (The WHOQOL



Group 1998) and according to Skevington *et al.*, (2004) its purpose was to make physicians more aware of the need to listen to their patients and take their feelings into account during treatment.

An advantage of HRQoL is that it offers perspectives on healthcare evaluation and methods that are different from medical and economic evaluations because it focuses on subjective measurements such as patients' perspectives of their health. It also picks up more subtle changes in health status so is useful in evaluating new treatments for chronic neurological conditions such as Parkinson's disease. The impact of healthcare intervention is therefore evaluated by patients from their own experience. HRQoL is widely used, and continues to expand and develop (The WHOQOL Group 1998, Skevington *et al.*, 2004, Smith *et al.*, 2005, Schmidt and Bullinger, 2007 and Ware 2007).

Despite this approach receiving increasing attention from international organisations, it has been criticised for inappropriately 'reflecting the specific understanding of health, functioning and quality of life by individuals in specific cultures' (Schmidt and Bullinger 2007:221). In addition, there are still significant populations who cannot be assessed by this instrument, such as people who have communication difficulties (stroke, learning disabilities etc). Thus, it is important that HRQoL measures are developed in order that they may be applied appropriately in each context in which they are used and do not neglect the specific problems of minorities (Skevington *et al.*, 2004).

### **3.1.1.3 The Patient-satisfaction approach**

While the first two approaches focus on the health-related aspect, the third approach focuses on the non-health-related aspect namely, patient-satisfaction approach. Why is patient satisfaction important? Many studies show that patients' satisfaction is associated with their recovery from illness and in many cases, the patients' progression in illness relates to their feelings towards the healthcare service which they receive (Wilkinson *et al* 1997, Jenkinson 1998 and Jenkinson *et al.*, 2002). Patients' subjective evaluations of healthcare services are increasingly important in assessing healthcare outcomes because of the current emphasis on a greater partnership between providers (therapist, doctor, and staff) and consumers (patients) in healthcare.

Patient satisfaction forms an essential tool to evaluate the performance of healthcare services by putting an emphasis on the people who receive and provide care (Smith *et al.*, 2005).

This approach assesses the social, psychological and ethical suitability of the way in which people are treated by health services. This approach is described by Smith *et al.*, (2005) as 'evaluating humanity' because it reflects patients' satisfaction, expectations and perceptions of the actual care provided.

Patient satisfaction can be defined as 'patients' personal evaluation of health care services and providers' (Marquis *et al.*, 1983). Patient satisfaction is affected by many variables associated with healthcare services, as well as by individual factors such as socio-demographic characteristics, physical and psychological statuses, and attitudes and expectations concerning various healthcare services that patients receive (Cleary *et al.*, 1988, Minnick *et al.*, 1997 and Williams 1994, Williams *et al.*, 1998). There are five major factors that have an effect on patients' satisfaction: interpersonal skills of health professionals; information giving from health professionals; technical competence; the organisation of healthcare and time spent with the patient (Fitzpatrick 1997 cited in Smith *et al.*, 2005). The primary benefit of this evaluation is that it places emphasis on human beings rather than on disease or health-related outcomes. It also helps to avoid inhumane incidents occurring in the healthcare service such as lack of respect for patients' or relatives' dignity or autonomy (Smith *et al.*, 2005).

Despite the fact that this method emphasises the satisfaction of the healthcare user, it is considered an inappropriate method for the process of monitoring and improving the quality of healthcare policy for the following reasons. Firstly, it has been suggested by scholars that there is a lack of theoretical underpinning of measurement of satisfaction in healthcare (La Monica *et al.*, 1986; Sitzia and Wood 1997; Staniszewska and Ahmed 1999, Rogers *et al.*, 2000). There appears to be agreement within these researchers that satisfaction is a dynamic concept the meaning of which can change across care settings and client groups. For example, there are systematic response biases in the way people respond to satisfaction scales which may give the illusion of greater satisfaction among those receiving the worst care. This may be owing to low expectations and a reluctance to complain on the part of patients and thus it may not provide a valid measure of the experience of most. Second, it has been suggested that one common problem with survey measures of satisfaction is that it may contribute to inflationary results

(Avis *et al.* 1997; Williams 1994; Williams *et al.*, 1998). Therefore, the dimension ‘satisfaction’ should not be employed only to assess performance of healthcare services.

#### **3.1.1.4 Economic Evaluations**

The fourth healthcare evaluation method is based on economics, including for example, the use of cost benefit analyses and metrics to enable healthcare rationing. This form of evaluation of health programs originated in the 1960s (Johannesson 1996) and has been widely used by health economists (i.e. Dupuit 1844; Pareto and Kaldor 1939; Sir John Hicks 1939 and 1941 and Mishan (1971) cited in Johannesson 1996). According to Drummond *et al* (1996) economic evaluation refers to a comparative analysis of alternative courses of action in terms of both their costs and consequences. Choices inevitably have to be made regarding the allocation of resources as there is limited money available and this method guides the allocation of scarce resources to achieve optimal benefit by measuring both the benefits of healthcare and also the costs involved in providing it. Smith *et al* (2005) explained that a number of methods of economic analysis are widely used in the field of healthcare evaluation: Cost Effectiveness Analysis (CEA), Cost-Utility Analysis (CUA) and Cost-Benefit Analysis (CBA). These are described below.

CEA is an economic evaluation methodology with outcomes measured in health units. This method aims to find the most efficient treatment option in terms of cost per unit effect. It is used when the healthcare programmes may have differential success in outcome, and differential costs, but outcomes must be common to both programmes (e.g. life years saved; pain-free days gained; blood pressure reduction).

CUA is an economic evaluation where outcomes are measured in health units in terms of quantitative and qualitative aspects and benefits are considered in terms of utility rather than monetary valuation. It can be seen as an improvement on the CEA as it attempts to combine more than one outcome measure and thus should be considered as the method of choice when quality of life is an important outcome. Utility based measures are usually expressed in terms of quality adjusted life years (QALYs) gained.

CBA is an economic evaluation technique in which outcomes are expressed in monetary terms. This method aims to measure both the costs and benefits of treatments

in order to determine the net benefit. This method differs from CEA and CUA analyses because the cost and benefits of healthcare are expressed in the same units. There are two main approaches: the human capital approach and the willingness to pay approach. The human capital approach is derived from ‘human-capital theory’ by Becker (1964 cited in Johannesson 1996:2) which explains that better human capability can be defined in terms of better health and work efficiency. Investment in the healthcare system leads to a positive effect which increases human productivity; when people are in good health, they tend to work better.

The advantage of carrying out an economic evaluation is that it allows evaluators to identify, measure, value and compare the costs and consequences of alternative courses of actions (Drummond *et al.*, 1996). It also assists healthcare and government agencies to decide how to allocate their scarce resources across a wide range of healthcare interventions. Furthermore, it can be used for determining healthcare interventions that produce the greatest health gains, when there are limited resources (Smith *et al.*, 2005), for example, the provision of oral rehydration salts to treat childhood diarrhoea. In order to assess the quality of health service, the economic evaluation is used for examining whether healthcare project investment generates a reasonable health outcome given the financial costs.

There are, however, limitations to this approach, as, in particular, it focuses on economic factors rather than human aspects. Culyer (1983) claimed that this method opposes the medical evaluation approach because it emphasises financial aspects rather than human beings. That is to say, a question similar to ‘is patient health improved?’ is the most widely used in a medical appraisal, but for economists the question would be ‘is the benefit greater than the cost?’

Another fundamental problem of using economic evaluations such as cost-benefit and cost-effectiveness in healthcare can be explained by the theory of opportunity cost<sup>21</sup> of Buchanan (1969). Buchanan (1969) pointed out ‘Cost in the predictive models of economics must be objective. If cost is introduced into logic of choice, however, it is obviously subjective’ (1969:47-48).

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<sup>21</sup> This is a key concept in economics in particular related to decision-making processes where the decisions involve with ‘cost’ and ‘choice’.

This quote highlights the distinction between the actual cost and opportunity cost. Buchanan (1969) explained that whereas the actual cost or normal cost can be measured in units or resource input in an objective way, ‘opportunity cost’ is subjective and is related to choice. Therefore in order to evaluate healthcare utilisation, the theory of opportunity cost is important in particular when ‘healthcare’ is considered by people as a choice. This is because when people are making choices it is their own rational decision and the choice they make is only meaningful to them (Buchanan 1969).

According to Sassi *et al.*, (2001) the cost-benefit and cost-effectiveness approach also ignore the equity dimension by treating every person and every condition the same and not acknowledging the ethical priority usually given to saving a life. Sassi *et al* argued:

‘By neglecting this dimension [equity], economic analysis loses much of its normative power and restricts itself to a relatively narrow role in supporting healthcare decisions (Sassi *et al.*, 2001:1)’.

The nature and concept of economic analysis is limited because it focuses on the price mechanism, which relates supply to demand. Thus it tends to lead decision makers towards the maximisation of health gains within resource limitations, and is thus usually less sensitive to the issue of who benefits from healthcare interventions, in terms of individuals or population groups (Sassi *et al* 2001). Most of the distribution of healthcare facilities under this assumption and evaluation is therefore based on ‘market-orientation’. Johannesson (1996) argued that this approach focuses on cost in monetary terms and thus assigns negligible benefits to poor people who have less ability to pay and have fewer chances to access healthcare services as compared to the rich, which creates problems of inequity. As a result, this method alone cannot be used as an appropriate measurement for healthcare systems, in particular regarding a universal healthcare system which has the aim of improving equal access to healthcare. To address this problem, equity can be included in the economic evaluation through developing the ‘Evaluating equity’ approach.

### **3.1.1.5 Evaluating equity**

Equity has increasingly become a key concern of those carrying out economic evaluation (Sassi *et al* 2001). It attempts to include considerations of social justice

(for example, actively addressing existing health inequalities) and aims to reduce healthcare inequality by providing healthcare resources to members of the community in an equitable way (Smith *et al* 2005). According to Oliver and Mossialos (2004), although a vast literature on equity in health and healthcare exists, there is little agreement over what this notion means. A commonly accepted definition of equity is based on two main concepts: fairness and distribution (Aday *et al* 1993, Smith *et al* 2005). Smith *et al* (2005) defined equity as ‘the concept of fairness, justice and equality’ (Smith *et al* 2005: 181) and in the context of healthcare, this means that health services should be distributed with fairness i.e. not just to a rich elite, but with equal access for the poorest in society.

There are different ways in looking at the issues of equity, for example, horizontal and vertical equity. Smith *et al.* (2005) defined horizontal equity as the equal treatment of individuals or groups in the same circumstances. Vertical equity is defined as the principle that individuals who are unequal should be treated differently according to their level of need. Mooney and Jan (1997) compared horizontal and vertical equity with dividing a cake between persons A and B where both like cake equally. In the horizontal equity context, they should have a choice of choosing a cake, and receiving the same amount of it. However, in many situations it is not fair for A and B to have the same amount of cake, for instance, when A is starving and B has just finished dinner. This is because one might argue in the context of vertical equity that A should have a bigger piece of cake. Moving on from this example, in healthcare, horizontal equity refers to equal treatment for equal needs, that is, patients with similar illness should have equal access to healthcare resources. On the other hand, vertical equity refers to unequal treatment for patients with different levels of needs, that is, patients with more need should receive more treatment. Furthermore, vertical equity can apply to cases where patients have different income levels which might include devoting more resources to patients with lower incomes.

Aday *et al* (1993) explained access to healthcare and utilisation regarding effectiveness, efficiency and equity as follows:

1. Effectiveness of the benefits of medical care. An indicator for measuring effectiveness is an improvement in health.

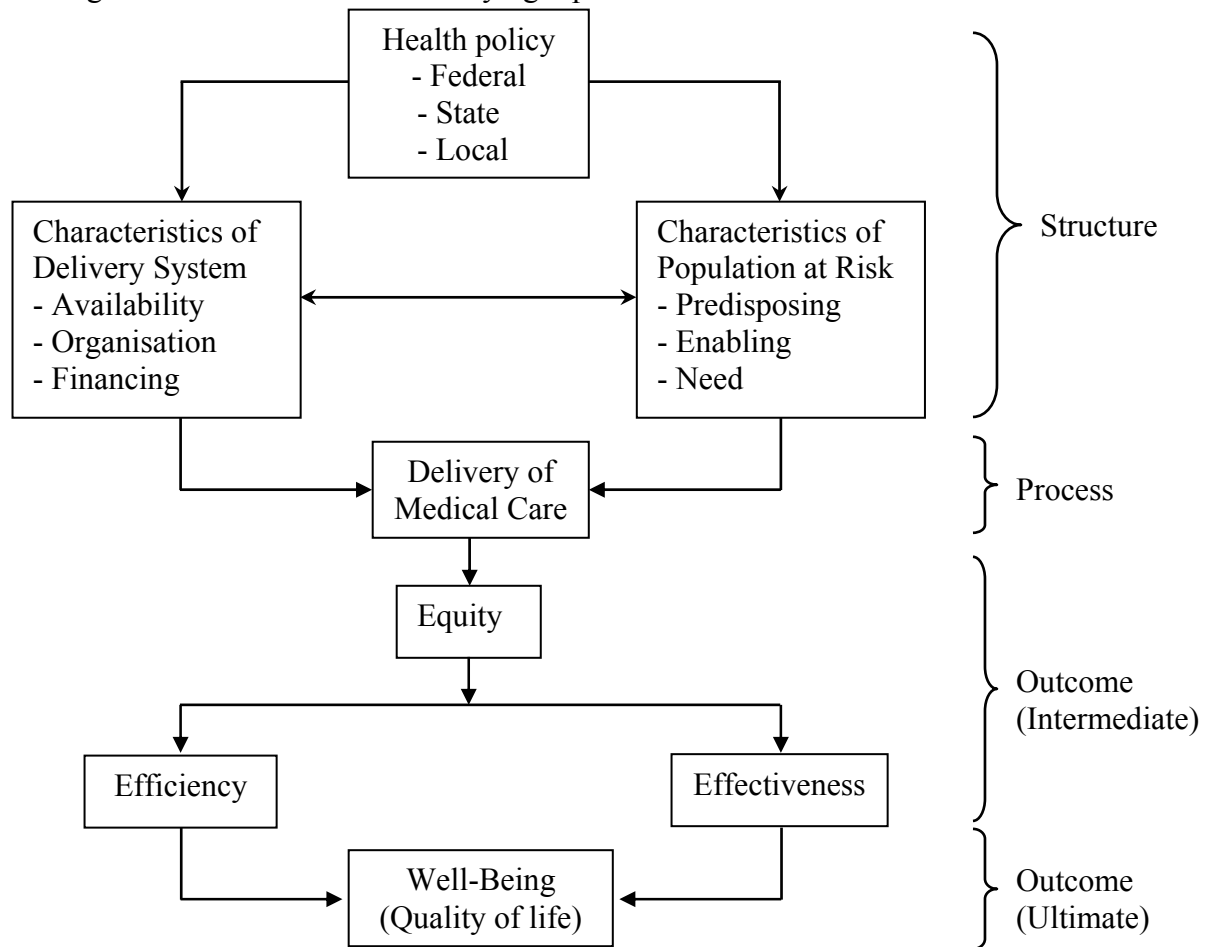
2. Efficiency shows the relationship between health improvements and the resources required.
3. Equity refers to benefits and burdens of medical care assessment of fairness in distribution.

Moreover, Aday *et al* (1993) highlighted the importance of wellbeing in the context of healthcare and explained the connection as follows:

‘Improvements in health not only include the sum of individual benefits, that is, reduced mortality rate, increased life expectancies, and decreased prevalence of disease, but also refer to a distribution of disease and health such that overall economic productivity and well-being are maximized’ (Aday *et al* 1993: 1).

Aday *et al*’s (1993) framework for classifying topics and issues in health care service research is shown in Figure 3.1.

Figure 3.1 Framework for classifying topics and issues in health care service research



Source: Aday et al, 1993:7

Figure 3.1 illustrates the linkage between health policy and wellbeing. It examines the impact of healthcare policy on the delivery system and identifies the populations affected by these initiatives. This model assumes that equity of access to the system, reflected in who gains entry and how often patients use services, has a direct impact on the efficiency and effectiveness of the care that is delivered, and ultimately, on the wellbeing or quality of life of the population it was intended to serve. As can be seen, the health policy analysis given in Aday et al's (1993) framework is mainly focused on medical care and 'wellbeing' as an outcome of health policy.

Evaluating equity provides essential value to healthcare evaluation and equity is recognized by many organisations to be an important policy objective. This evaluation approach prevents the evaluators from relying on purely economic evidence in their decision (Sassi *et al* 2001). In addition, this evaluation seeks to discover inequity in



resource allocation in order to provide greater resources to those who are disadvantaged in society (Smith *et al* 2005).

Although it is possible to define equity in general terms, it is difficult to measure in practice. Sassi *et al* (2001) conducted a systematic review of empirical economic healthcare evaluations in terms of the equity dimension of healthcare. The reviewers argued that previous studies did not address clearly the equity dimension and did not provide adequate information about policy implications thus bringing into doubt whether policymakers could form any policy suitable for the healthcare system. Evaluating equity is one of the most powerful methods of assessment (Sassi *et al* 2001), however, it provides only a partial evaluation of the healthcare system and therefore there needs to take into consideration other factors in the context of the whole healthcare system.

In summary, healthcare evaluations are clearly important for both policy makers for the people and for whom they aim to improve services. However, each evaluation approach has its own strengths and weaknesses thus no single approach has yet covered all aspects of healthcare evaluation. For example, the medical approach which emphasises improving the health of the patient is less focused on aspects of patients' satisfaction or fairness in financing, whilst the economic evaluation which focuses on resource allocation overlooks patient health and patient satisfaction. Therefore the evaluation which is useful for clinicians often differs from that useful to economists and evaluators have to decide which approach is appropriate to each healthcare system, according to the potential user i.e. clinicians, economists or policy makers. Ovretveit (1998) suggested the following 'purpose questions' which are essential for a determining what serves as a useful and valid evaluation:-

- Who is the evaluation for?
- What are the questions it aims to answer?
- Which decision and actions should be better informed as a result?
- How much resource and time are available, is it possible to achieve the purpose with these or should the purpose be more limited, or should time and resources be increased? Ovretveit (1998:27)

As regards to methodology, both qualitative and quantitative methods can be used to evaluate a healthcare system, according to Macmillan 1996. Quantitative methods are appropriate when evaluators know exactly which aspect needs to be evaluated, e.g. financial allocation and priority setting in a healthcare system, census, or a national survey on the demand for a healthcare service and Clinical Information Systems (CIS). Qualitative methods are suitable for studying in-depth selected cases, events or issues as they focus on the experiences and perspectives of individuals and are most appropriate when the evaluators are unable to decide in advance which issues are important. For instance, these issues may encompass cultural, historical and political circumstances, which influence the nature of healthcare and its delivery (Macmillan 1996; Hall 2004). Hall (2004) argued that quantitative indicators are not adequate to evaluate healthcare. Hall (2004) proposed a ‘situational’ healthcare evaluation which she argues is ‘meaningful to the diverse stakeholders and could lead to a richer understanding of healthcare’. Hall (2004) further pointed out that it reflects the context of the specific healthcare environment.

The partial nature of existing approaches to healthcare evaluation in Thailand will be demonstrated in the next section, which describes how the UC scheme has been evaluated. The example is used to illustrate the pitfalls of the existing healthcare evaluation and to introduce a wellbeing approach, which incorporates a broader perspective that could be included in the UC scheme evaluation.

### ***3.1.2 The UC evaluation in the Thai context***

The UC scheme has been operating in Thailand since 2001. Since its inception there have been a remarkable number of evaluations carried out by different stakeholders. However, these evaluations do not give sufficient consideration to the fact that the healthcare system in Thailand and that Thailand as a nation is constantly changing. Most notably the introduction of the notion of wellbeing to official health policy discourses has not been accommodated in the evaluations. In order to discuss the UC evaluation in Thailand, it is necessary to consider both what has been done and what still needs to be done. This section therefore reviews the main research studies explains how the UC has been evaluated and the next section proposes reasons why a wellbeing approach is needed.

To assess how the UC scheme performs in meeting its project target of ‘improving equal access to healthcare’, the UC evaluators have employed three main approaches: equity, economic, and patient satisfaction approaches. Themes for evaluation are concerned with equity in the UC, efficiency in the administration of the UC, and healthcare users’ satisfaction with the UC scheme.

### **3.1.2.1 Equity in the UC scheme**

Various research studies on equity in the UC were undertaken in order to evaluate whether the UC has provided the poor with better access to healthcare. In doing so a number of public health researchers have used the equity concept and economic methodologies to evaluate the impact of the UC scheme among different groups of people (such as Na Ra Nong *et al* 2005, Prakongsai 2004, Tangcharoensathien *et al* 2004, Pannarunothai 2000, Pannarunothai 2005 Prakongsai *et al* 2006 and Pannarunothai 2008).

Pannarunothai (2008) found that the UC scheme is widely supported and used by the poor. Pannarunothai (2008) further pointed out that in order to improve the wellbeing of poor households, a good health financing policy is needed, with mechanisms to improve service provision quality. The PCUs at local level have to be improved in order to achieve equity in both health finance and healthcare delivery. This is because the poor are more likely than the rich to seek care from the primary level.

A study by Prakongsai *et al* (2006) shows that although the campaign slogan of the UC scheme in 2001 was ‘30-Baht treats all diseases’, at that time the scheme did not include chronic renal failure. While civil servants and social security beneficiaries could access Renal Replacement Therapy (RRT), the UC beneficiaries could not. In order to extend treatment to those who suffered from kidney failure, National Health Security Office (NHSO) made attempts to solve the problem by providing financial support to the International Health Policy Programme (IHPP) to carry out research on RRT. Consequently, research into the possibilities of universal access to renal replacement therapy in Thailand was undertaken in 2005 (Tangcharoensathien *et al* 2005). Although RRT is not cost-effective, with the supposed/intended equity of the system, patients under the UC scheme should have access to RRT treatment and in this case, ‘care’ should be given higher priority than ‘cost’ (Tangcharoensathien *et al* 2005).

The government eventually announced that RRT treatment could be applied for by UC beneficiaries in 2008 (The manager, 2008).

### **3.1.2.2 Efficiency in administration of the UC scheme**

In terms of efficiency regarding the project administration, the evaluators employed both quantitative and qualitative methods to assess how well the UC scheme was managed and the quality of healthcare services that it provided (see for example, Na Ranong 2003, Konklang 2003, the Health System Research Institute (HSRI) and WHO (2004), Angkhasuwapala 2004, Wattanachi 2004 and The Public Health Commission 2002). These studies found that the effectiveness of the UC scheme has not yet fully succeeded in terms of its management and the quality of service delivered to those who used the service.

Konklang (2003) researched the quality of services by drawing on data based on the experiences and expectations of 230 primary care users in a hospital in Khon Kaen. The study revealed that the users were dissatisfied with the quality of services for a number of reasons including: the fact that the number of healthcare workers was relatively small; that diagnostic processes tended to be rather superficial and unlike processes experienced in the past; that there were no explanations in terms of the forms of treatment and, finally, that staff refused to provide services late in the afternoons. Moreover, patients with leprosy who required regular treatments were required to pay 30Baht for each visit, unlike previously when they used to get free services.

A monitoring report of the UC scheme by the Health System Research Institute (HSRI) and WHO (2004) identified four main problems. Firstly, the implementation of the UC was top-down from the central government. Local health administrators were left to resolve problems on their own and needed to learn how the scheme operated through operating it. Secondly, the hasty implementation of the scheme meant that local health administrators had little time for preparation and the information system was not completed. Thirdly, the UC initially operated through a process of trial and error as health administrators did not understand the rules and regulations of the scheme. Consequently, the administration of the UC was unpredictable. Finally, people had high expectations of the scheme as it had been advertised as ‘30-Baht treats all diseases’ and people interpreted this to mean that all diseases could be cured at a cost of 30 Baht. But

in fact, there were many conditions and treatments that the benefit packages under the scheme did not cover. This created problems between service providers and service users and led to people appealing against the UC regulations.

Angkhasuwapala (2004) recommended further development of the UC scheme to improve the management of service provision and address concerns relating to budgeting and expenditure control. He suggested that future work needed to focus on five main areas: services, budgeting, human resources, stakeholder participation, and information systems. Finally, Angkhasuwapala (2004) argues that any future research should acknowledge the ideologies that underpin the provision of universal coverage and the way that people choose healthcare services in order to identify suitable indicators for healthcare evaluation.

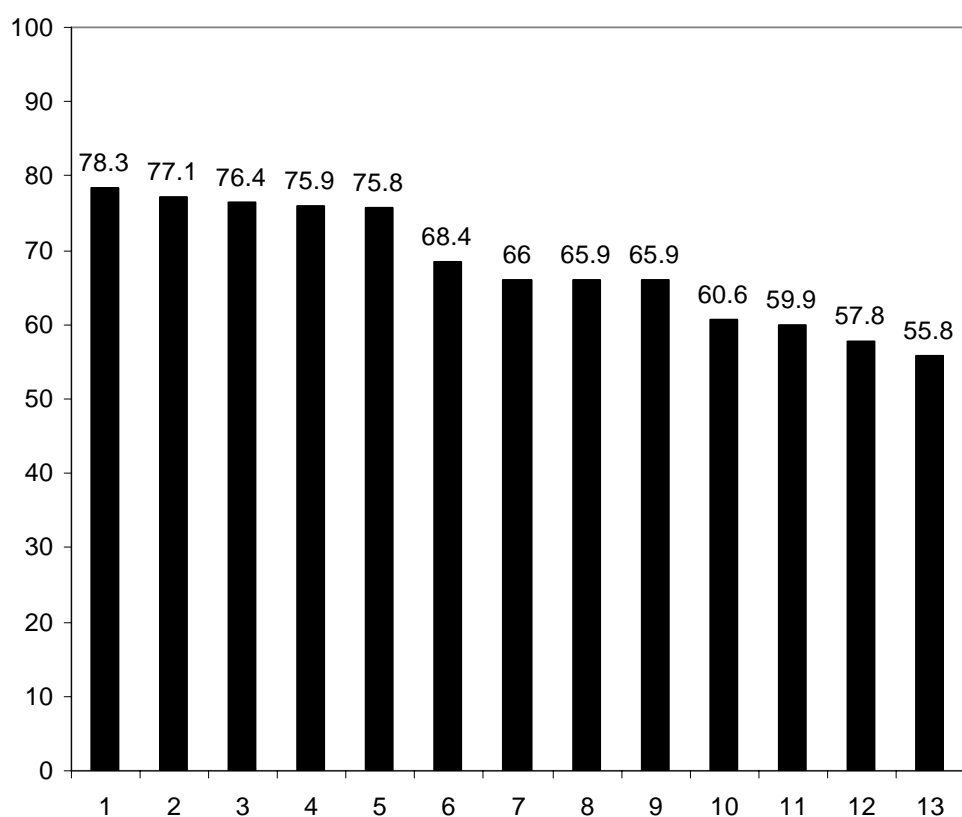
Wattanachai (2004) suggests that in order to help the UC scheme to achieve improvements in quality and efficiency, there is a need of greater participation from many sectors such as academics, NGOs, health administrators and user groups. Wattanachai (2004) argues that while initially this style of management might require a considerable amount of time, in the long run it will enable the UC scheme to be managed smoothly.

In summary, recent evaluations of the UC scheme have all observed that it continues to experience problems with regards to its management and implementation. Thus, the scheme clearly needs to be strengthened in these areas to improve its performance and the key way to identify how these problems occur at the local level is through a holistic evaluation method such as the WFE.

### **3.1.2.3 Satisfaction with the UC scheme**

The government has carried out regular assessments of people's satisfaction with its policies. For example, in 2004, a survey conducted by the National Statistical Office of Thailand found that of the 13 policies evaluated, the UC scheme was the one where people reported the highest level of satisfaction (78.3 %, see Chart 3.1).

Chart 3.1 Percentage of people reporting satisfaction with the UC scheme compared with other government policies



- |                      |                                     |
|----------------------|-------------------------------------|
| 1. Health            | 8. Transportation                   |
| 2. Sport             | 9. Politics                         |
| 3. Education         | 10. Social                          |
| 4. Tourism           | 11. Foreign affairs                 |
| 5. Economic          | 12. Security                        |
| 6. Public relations  | 13. Civil service monitoring system |
| 7. Money and finance |                                     |

Source: The National Statistical Office of Thailand, 2004

Surveys of the satisfaction of healthcare users are widely used as a form of healthcare evaluation, for example: The ABAC poll (2001), (2002), (2003), (2004), (2005), the Suan Dusit Poll (2002), the Bangkok Poll (2002) (Jongudomsuk 2004a). Of these the ABAC poll conducted by the ABAC Poll research centre at the Assumption University of Thailand is the most influential as it has been used by the NHSO each year since 2001 to evaluate the satisfaction of Thai people with regards to the UC scheme. The

results of the polls revealed that more than 80% of people were satisfied with the UC system (Jongudomsuk 2004a). The poll has received much attention because of the fact that it was designed to primarily ask questions about the success of the UC system rather than about any weaknesses and this issue will be discussed in next section.

### ***3.1.3 Criticisms of the existing approach***

Although the various evaluations currently used offer insights into particular aspects of the UC, they contain a number of weaknesses, some of which have been identified by academics and activists in Thailand (Na Ranong 2005, Samgoses 2006, Pannarunothai 2008). Some of these criticisms are particularly relevant because they support the argument in favour of the approach and analysis proposed in this thesis. The main weaknesses of the existing evaluations can be summarised as follows:-

1. The large scale and quantitative nature of the evaluations produces abstract and general data. It lacks any sense of ‘thick description’ (Geertz 1973) or context-specific insights, which could lead to a richer understanding of healthcare and wellbeing.
2. The existing evaluations are not very sensitive to changes in Thai society and the overall healthcare system in Thailand.
3. Most of the evaluations, usually commissioned by the Ministry of Public Health, are dominated by a narrow focus on health, and adopt traditional evaluation methodologies.

The next section addresses each of these points and discusses the relevance of the criticisms in more detail.

#### **3.1.3.1 Emphasis on large scale and quantitative method**

Most evaluations on healthcare users’ satisfaction in Thailand are based on large-scale quantitative methods such as questionnaire surveys. Although both qualitative and quantitative methods can be used to evaluate peoples’ satisfaction, most evaluation carried out in Thailand has usually deployed a quantitative methodology. A survey with a set of statements using rating Likert’s scales such as ‘very satisfied’, ‘satisfied’, ‘moderate’, and ‘not satisfied’ is one of the popular ways of using a quantitative method

for measuring patient satisfaction. These methods do not probe in sufficient depth so as to assess clearly the wellbeing of health service users.

As stated above one of the most well-known UC evaluation methods since its implementation in 2001 is the ABAC poll. The poll consists of attitude surveys carried out on two population groups: people over 15 years old who possess cards entitling them to UC services and the staff who provide services in the medical establishments under the UC system. For the survey, questionnaires are distributed to users and medical workers in different provinces. A random sampling technique was employed to select the target sample by taking into account that, statistically, the sample did not represent the entire population.

A problem of the UC scheme is demonstrated in ABAC Poll in 2005. It was found that 36.7% of the sample considered making an appeal when they experienced problems but the percentage of people actually making an appeal was only 1%, which may suggest that the accessibility of the appeal process needs investigation. This example indicates firstly, that people's attitudes and behaviours are not necessarily identical and secondly, that simply because 80-90% of people said they were satisfied with the UC system, it does not follow that problems do not exist.

An important criticism of the ABAC Poll is the view that 'polling is not public opinion' (Samgoses 2001). The reason for this is that respondents to the poll are not systematically sampled to ensure that they represent the Thai population as a whole and as a result the findings cannot be generalised to this population. For this reason, the director of this poll argued that the nature of 'polling' is a 'guesstimation' rather than 'estimation', and in this sense he agreed with Samgoses' critique that polling should not be understood as a simplistic gathering of public opinion. However, he argues that the poll is a survey of people's opinions so it could still be a useful tool for making informed decisions for politicians. Thus the poll is regarded as being preferable to not having any vehicle for the expression of public sentiments (ABAC Poll, 2006).

One can argue that these types of polls are beneficial in terms of revealing the general views of people and service providers; to a certain extent they could be used to improve and develop the UC system further. For example, Helliwell (2007) argues that the Gallop Word Poll, which was used in more than 130 countries, is a powerful measure of



life satisfaction as it has included the social context of wellbeing. However, this is not the case for the ABAC poll with its reliance on a questionnaire survey. Not only does it lack depth, it does not place the emphasis on people providing explanations for their opinions. Therefore, such surveys usually fail to achieve novel discoveries that are often hidden behind the respondents' answers.

### **3.1.3.2 Lack of sensitivity to the changes occurring in Thailand**

The evaluations of the Thai healthcare that have been undertaken to date do not reflect the fact that the healthcare system in Thailand is currently undergoing transformation in two significant ways, namely: the changing definition of health and greater emphasis on wellbeing within Thai policy. These will now be discussed.

As mentioned in Chapter 2, the definition of health in Thailand has been the move away from a narrow definition towards a broader concept. Previously, the goal was to ensure that everybody had good health and thus the WHO slogan 'Health for all' was adopted to make the concept more easily accessible to the public. However, at present, the slightly different notion of 'All for health' is used in Thailand, meaning that health is linked to almost every social issue and that it requires cooperation from all parties (Jindawattana 2003 :150). The word 'health' is translated into Thai as '*Sookaparb*'. However, Jindawattana (2003) uses this interchangeably with the word '*Sookka Pava*' which translates into 'wellbeing' in English. More importantly, the word '*Sookka Pava*' (i.e. wellbeing) is increasingly used in many documents produced by researchers who work in the field of health; particularly within the National Health Commission Office - NHCO (see for example the NHCO's website). This suggests that the increasing use of the term 'wellbeing' in relation to health is understood to offer a more holistic approach to understandings of 'health'.

To this end, some Thai health organisations have broadened their working definition of health to include peoples' social and spiritual dimensions. In so doing, they have reorientated their interpretations of health from a narrow concept focusing on health in terms of illness and curing disease, to a far broader understanding that embraces wellbeing. This has had an impact on health policy, which nowadays must take into

account a wider range of factors that expand beyond health per se to include broader aspects captured under wellbeing. This concept is illustrated in the WHO's argument that the wellbeing of billions of people around the world - that is to say, the quality and length of their lives - depends amongst other factors on the performance of health systems.

For some decades physicians and health workers from MoPH have moved towards a broader concept of health as can be seen in numerous studies run by organisations, such as those listed below. The roles of some of these organisations were explained in Chapter 2.

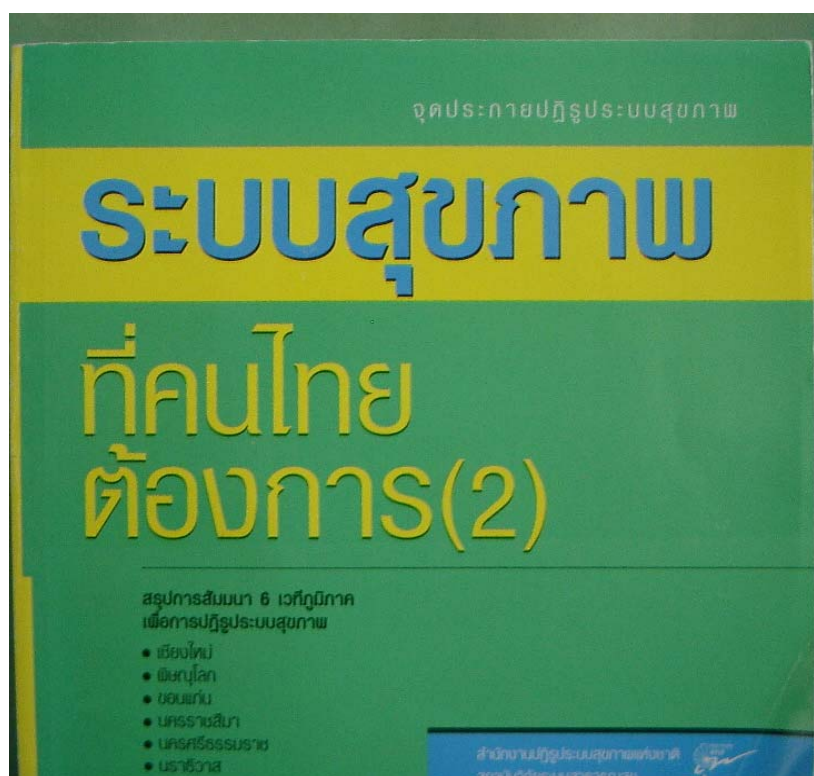
- National Health Commission Office -NHCO (2008)
- Health Insurance System Research Office -HRSO (2005)
- National Health Security Office -NHSO (2002)
- The Thai Health Promotion Foundation -ThaiHealth (2001)
- National Health System Reform Office -HSRO (2000)
- Department for Development of Thai Traditional and Alternative Medicine -DTAM (1999)
- Health System Research Institute- HSRI (1992)

Many physicians have supported the move towards linking health and healthcare systems more closely with other dimensions of society. Amongst physicians who have played an important role in the development of the healthcare system in Thailand, are three notable figures: Wasi (2000, 2006), Thammawarangoon (2004) and Chuengsatiansup (1999; 2002; 2003).

Wasi (2000) is a public health expert whose contribution in the field includes several reforms of the Thai healthcare system. He is widely recognised as a doctor who has dedicated himself to making society, both domestic and international, better. One of Wasi's important contributions is that of '*Sam Liam Ka Yeon Phu Kao*' translated as 'A Triangle that moves The Mountain' part of which was explained in Chapter 2. Having pursued a career in the health industry for decades, Wasi (2006) proposed that important changes will be achieved when three societal elements are well connected: knowledge, civic movement and state power.

This idea has been accepted and employed as a framework for health system reforms that has greatly influenced the introduction of universal healthcare coverage in Thailand in 2001. The idea has successfully encouraged structural and strategic changes within Thailand's healthcare system.

Figure 3.2 An example of a book that contains original ideas from the UC scheme.



Translation of Thai words: The Health System that Thai people need (volume II).  
Source: The national Health System Research Office, 2000.

The second physician is Thammawarangoon who demonstrate how health problems in the province of Khon Kaen were derived from the poverty and debt of many farmers (Ekachai 2004). Owing to high levels of chemical supplements used to increase crop production, debt became pronounced and resulted in farmers working harder to relieve their financial pressures. Consequently, many health problems ensued amongst the population because of individuals becoming overworked and stressed as well as suffering from the physical effects of the extensive use of chemicals. Thammawarangoon pointed out that 'If this social malaise is not healed at its roots, hospitals will be forever overcrowded, our country's medical expenses forever

spiralling and every one of us - doctors, patients, hospital staff, will drown in distress' (ibid 2004). According to him, the treatment of patients should also be concerned with their livelihoods, and problems such as poverty and indebtedness. In 1996, Thammawaranggoon and his wife, who was also a doctor, established the Sustainable Community Development Foundation in rural Khon Kaen in order to address their patients' problems by deploying the concept of sustainable development alongside medical care. Examples include a compilation of essays published by the centre for Bhutan Studies, *Beyond Disease Prevention and Health Promotion: Health for all Through Sustainable Community Development*, which expresses a broader view of health (Thammawaranggoon 2004).

The last researcher, Chuengsatiansup (1999), applied an anthropological methodology to a cultural study of a northeastern community to investigate 'spiritual dance'. In Northeastern Thailand, villagers believe in a local norm called '*Heet-Sib-Song Kong-Sib-See*'. This states that people in the village have to support each other through making donations and performing religious activities that motivated acts of merit. Anyone that violates this code of conduct will, so it is thought, endure chaotic personal problems that may have implications for the wider community, owing to otherworldly consternation.

In this culture, ritual dance is one of the many local traditional healing practises and a common belief is that the villagers' ancestors and spirits cure their illnesses. Dance therapy involves the use of a local musical instrument called a '*Can*<sup>22</sup>' and a medium (usually a woman) who dances to the tune of the music to heal patients. This ceremony begins with the summoning of the spirits to possess the medium, then the possessed medium dances, diagnoses the sickness, and finishes with another dance for curing the patient. This treatment costs very little in terms of paying for the medium. Chuengsatiansup (2002) claimed that this procedure can effectively help those who are superstitious and treat patients alongside the administration of modern medical care. He argued that this is a mental and spiritual treatment which has implications for the patient's successful physical recovery. He consequently proposes that spiritual health should be incorporated into any health impact assessment (Chuengsatiansup 2003). He argues that mainstream scientific thought has been dominated by 'objectification' and

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<sup>22</sup> A traditional musical instrument made of bamboo famously used in the north-eastern part of Thailand

‘verbalisation’ and has posed the main obstacle to the inclusion of spirituality as a component of health impact assessment. In Chuengsatiansup’s view,

‘Mainstream scientific thought, which has been dominated by Newtonian and Cartesian paradigm, is characterized by its reductionistic and materialistic worldview. In this paradigm, a complex whole (be it an ecological system or a living organism) is viewed as reducible and can be explicable only by objectively examining and measuring its components. In other words, the whole is understood in this paradigm by the properties of its parts. Spirituality as an aspect of life belongs to a differing paradigm of thought with entirely different ontological and epistemological assumptions. Spirituality is an emergent property of a complex living system and exists only when such a system is examined in a holistic manner’ (2003:3).

Drawing on the work of the above researchers, it can be seen that there have been various attempts to broaden the concept of health in the Thai context from an objective based perspective to a more subjective and holistic one. It is in this context that the broadening interpretation of health has promoted increasing attention on ‘wellbeing’ as the ultimate goal of the UC scheme.

Recently, the Thai government has been using the discourse of ‘wellbeing’ in its development policies, including that of the UC scheme. This rhetoric of wellbeing is adopted by the NSHO who has stated that ultimate goal of the UC scheme is to promote the wellbeing of Thai people. Box 3 below illustrates that the NHSO’s vision is to create a health care scheme that promotes wellbeing as its ‘ultimate goal’. Although its goal is clear, there is no evidence that an evaluation of the UC has been carried out using a wellbeing approach for Thai people.

### Box 3.1 The history of the National Health Security Office (NHSO)

The NHSO was founded in accordance with the 2002 National Health Act in order to follow the government policy in providing access to universal health insurance to all Thai people. All Thais should receive services in an equity and equality way in relation to their needs with efficient management and administration. The service is provided with the consideration of people's own rights to choose their healthcare service. This includes a good relationship between service-minded providers and service users.

The administrator team and all of the NHSO staff are ready to untiringly follow our missions and to create a new working environment according to the new image of the organisation, of which the 'wellbeing' of Thai citizen is an ultimate goal.

Source: Summarised and translated from Thai to English by the researcher (The National Health Security Office -NHSO, 2007).

Since 2002 the concept of wellbeing has been promoted throughout health reform programmes in Thailand. Health reforms are underpinned by the idea that healthcare is not merely a matter of hospitals, medicines, medical technology, doctors, nurses, as organised by the Ministry of Public Health but that health comprises 'wellbeing' (MoPH 2005). The Health Systems Research Office (HSRO) put forward that wellbeing can be regarded in the Thai context as '*Yuu Yen Pen Sook*', literally meaning 'live calm, be happy' (HSRO, 2005).

The promotion of wellbeing has been widespread and ongoing. In 2005 the HSRO organised a national health assembly on '*Yuu Yen Pen Sook*' (wellbeing), as a special event, at which the common aim to generate wellbeing throughout society was announced, the intention to design a measurement of wellbeing was made and the phrase 'wellbeing society' was coined. The conclusions of the meeting comprised six elements (HSRO 2005). Firstly, Thai people had specified the ideal characteristics of societal wellbeing, which was to achieve a 'sufficient living' as suggested in the King Bhumibol's philosophy<sup>23</sup>. Secondly, people and society must have good relationships, in other words, people should be happy within their hearts, following their religious philosophies and living in a society that has a relatively strong socio-economic infrastructure with decent environments. Thirdly, it is essential for an individual to have a loving and supportive family, as well as be part of a community where the members help one another. Fourthly, people should adopt the principles of 'sufficient living', which entails decreasing unnecessary consumption, make savings, and be self-reliant.

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<sup>23</sup> This will be discussed in greater depth in section 3 of this chapter.

Fifthly, having effective social and value systems, good government policies, and healthcare service systems is important in society. The last point stated that it is vital to acquire specific strategies to transform contemporary society into one founded on the concept of wellbeing. The strategy that was created was adopted from Wasi's notion: 'A Triangle that moves The Mountain' (Wasi 2000), introduced above.

In 2006, the Health Systems Research Office-HSRO arranged another event for the national health assembly. The King's speech on a 'sufficiency economy' formed the core concept for the meeting namely, 'sufficiency economies lead to a wellbeing society'. The idea of having an 'Asian health policy centre and health insurance scheme within the sufficient economic route' was proposed in the meeting as a guideline on which to develop national policies in the future (HISO, 2006).

Therefore, wellbeing is promoted as offering a greater, all-encompassing meaning than currently captured by the word 'public health' and 'healthcare'. From this understanding, although healthcare services are considered as forming only one component of wellbeing, they are still crucially important to the general health of the people in the country.

### **3.1.3.3 Dominance of 'traditional' evaluation concepts and methodologies**

Although debates over healthcare in Thailand are becoming more widespread, most evaluators of the UC are experts from the MoPH, which in fact forms a small number of people (Na Ranong 2005). Na Ranong is one such evaluator who has been evaluating the UC for a number of years (Na Ranong *et al* 2002, 2003, 2006) and has highlighted the lack of a broader evaluation concept as one of the UC scheme's key problems.

This supports the assertion that existing methods are inadequate for evaluating the wellbeing of healthcare service users. The methods currently used need to shift beyond 'traditional' healthcare evaluation processes, in order to grasp the changing healthcare system and capture a more nuanced understanding of health. Any evaluation should account for economic and social changes (both domestic and international) in order to provide an accurate assessment for better quality healthcare provision. Such an assessment should focus on a broader understanding of health that captures peoples'

wellbeing and covers all relevant aspects of their health, which current methods struggle to do at present.

Similarly, NHSO 2004 pointed out that the concepts and methods of evaluation need to be improved. One of the main concerns regarding the previous healthcare evaluation (such as the PMS-Performance Management System and the result based budgeting system) is that it focused on the system rather than people. It is argued that this type of evaluation is limited by time and inappropriate indicators, for example, setting a goal of overall health improvement within a short period of time such as in one year is hard to do in practice with constraints of time, budget, and human resources. From a health administrators' perspective this target indicator for evaluation is set to be very high and is unrealistic, and as a result is creating more problems to health administrators rather than enabling them to improve their work (Jongudomsuk 2004b). Jongudomsuk (2004b), therefore, suggests that the evaluation should become broader, constructive and creative instead of focusing on 'finding faults'.

However, before turning to the construction of a new approach to evaluation in section 3, it is essential to define the concept of wellbeing that will be used to inform the researcher's analysis of the Thai UC scheme.

## **3.2 The concept of wellbeing**

### ***3.2.1 Different approaches to understanding wellbeing***

The term 'wellbeing' is increasingly used in academic circles and in daily life. However, there is no consensus on a single definition of wellbeing (Gasper, 2007; Gough et al., 2007). Although the term broadly captures some notion of the 'good life', in other words it is a positive concept, its interpretation and meaning varies for different people and contexts, and it has been studied from many philosophical and disciplinary perspectives, resulting in various definitions and approaches. Nevertheless, there appears to be agreement within most of the literature that it captures three elements: the objective circumstances of the person, a subjective evaluation of their circumstances, and a relational and dynamic concept (Gough et al., 2007).

Throughout the years, there have been a number of approaches aimed at gaining an understanding of wellbeing. These are detailed below.



In the late 1970s, the basic needs approach focused on addressing how economic growth did not trickle down to the poor. It argued for the provision of a basic standard of living, such as the possession of commodities, rather than the growth of income. However, its focus on commodities neglected the fact that peoples needs vary. Thus, this approach was too general to explain wellbeing and failed to capture important dimensions such as human development, resources and agency, subjective wellbeing and quality of life (e.g. the work of the World Bank, Maslow, 1966; Doyal and Gough, 1991).

The human development approach, used by the UNDP, was a progression above the basic needs approach because of its recognition of how human development encompasses the process of increasing people's choice as well as the level of their attained wellbeing. However, while it is important for people to have wider choices to develop their potential, this approach did not explain the conditions under which people could utilise their potential (see also Sen, 1999; and Nussbaum, 2000).

The resource and agency framework addresses some of these concerns by exploring the ways in which people make use of a wider range of resources and strategies in order to achieve wellbeing. This approach goes beyond economic criteria by including people's social and political situations. Examples of these include the 'livelihoods framework' (Rakodi, 1999 cited in Gough *et al.*, 2007) and the Resource Profiles Framework (RPF) (Lewis *et al.*, 1991; Lewis and McGregor, 1992; Lawson *et al.*, 2000). While the former tends to explain resources on the basis of the use of 'assets' or capital, the latter focuses more on the social and cultural dimensions of agency in the use of resources. Although these approaches provide a more realistic framework, it is doubtful whether they can be applied well in terms of explaining rapid changes in the world (Gough *et al.*, 2007).

Finally, in order to address the lack of a measurement of peoples' feeling, the quality of life (QoL) approach was developed. This approach is premised on the idea that subjective wellbeing is an important aspect of people's lives and that a person should have an enjoyable life. In addition, it is evident that whenever one person is in a state of wellbeing, he/she is in a position to contribute to the wellbeing of other people and to society as a whole. For example, Lyubomirsky *et al.* (2005) point out that wellbeing has benefits for and contributes to communities and society. The empirical data they

reviewed showed that people experiencing wellbeing or happiness are more sociable, generous, creative, active, tolerant, healthy, altruistic, economically productive, and long lived.

The notion of QoL that covers the holistic elements of wellbeing, which are proposed from a social policy perspective, is due to Phillips (2006). Phillips (2006) provides a thorough and comprehensive exploration of QoL from individual to society, objective to subjective and theory to practice, drawing together all the major works in this area. However, this approach relies predominantly on the work of international academics that have largely remained distanced from the context of developing countries, and certainly from contemporary Thailand. As a result, reliance on this approach alone is insufficient for capturing the notion of wellbeing in Thailand.

In summary, the approaches mentioned above are not independent of each other; in fact they are all closely interrelated with the concept of wellbeing but are either too objective or too subjective and too universal. In addition, these approaches have been dominated by the 'West' and may not be particularly applicable to the Thai context, in particular within the vision of Thailand's development plan.

### ***3.2.2 Wellbeing as used in the Wellbeing in Developing Countries ESRC Research Group (WeD)***

This thesis has adopted the conceptualisation of wellbeing developed by the ESRC Wellbeing in Developing Countries (WeD) research group. This is because the WeD approach has addressed many of the gaps detailed above and offers a more holistic understanding of wellbeing that is specific to the social and cultural context of developing countries. In discussions of welfare regimes analysis, Newton (2007) and Copestake and Wood (2007) argue that a wellbeing focus to a regime analysis is more sensitive to the developing country context. Newton (2007) argues that a wellbeing perspective moves beyond the individual dimensions to account for the social and relational dimensions of wellbeing. In addition, Copestake and Wood (2007) suggest that an approach to regime analysis focused on wellbeing gives more emphasis to change, and is therefore more suitable in unsettled societies where there may be political instability. Copestake and Wood (2007) also argue that a wellbeing approach is more able to reflect the voices of those living in rural areas and recognises the importance of

empowering poor, marginalised and vulnerable people (Copestake and Wood 2007). For these reasons, a wellbeing approach is used to achieve the aim of the study. Furthermore, WeD's definition and approach embraces Thailand's recent national development goal, which emphasises 'people' and 'balancing between people and their conditions' (NESDB, 2009).

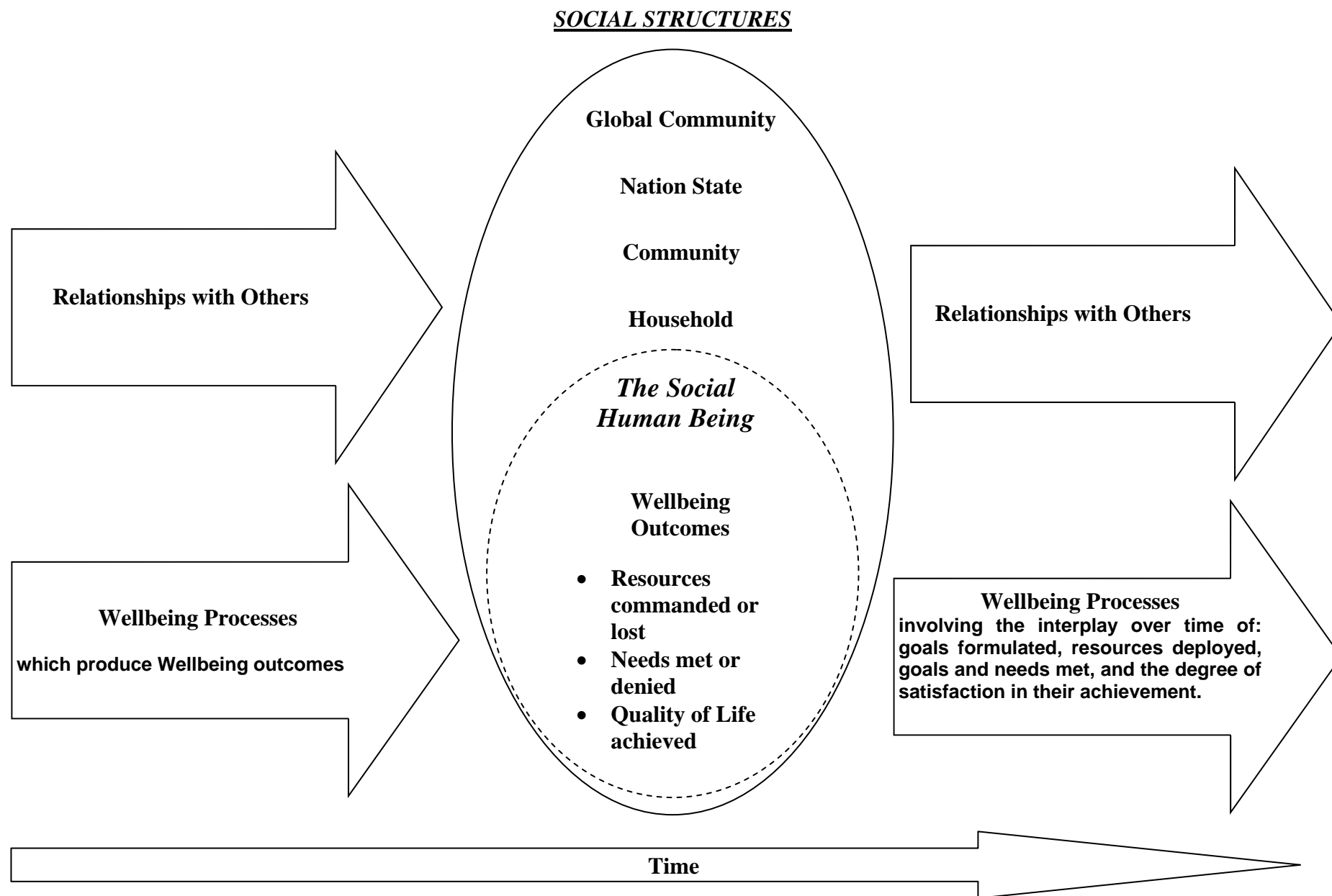
According to WeD, wellbeing is defined as 'a state of being with others, where human needs are met, where one can act meaningfully to pursue one's goals, and where one enjoys a satisfactory quality of life' (Gough and McGregor 2007). This is the definition adopted in this thesis because it not only highlights the three important aspects of people's wellbeing: needs met, acting meaningfully and satisfaction of life, but it also illustrates that wellbeing involves relationships with others. For example, the illness of one family member can bring great financial or emotional pressure on the whole family.

The WeD approach provides a way of understand wellbeing in three areas. Firstly, wellbeing is established by combining external observations of peoples' circumstances and their subjective perceptions of their condition. Secondly, wellbeing is not only an outcome, but a 'condition of being' that arises from the dynamic interplay of outcomes and processes. Lastly, the interplay between outcomes and processes is firmly located in society, and shaped by social, economic, political, cultural and psychological processes (McGregor 2004).

In order to research wellbeing, the WeD project encompassed perspectives from various disciplines, such as: sociology, economics, psychology, social anthropology and social policy. Different research tools such as the Resource And Needs Questionnaires (RANQ), WeDQoL and process research methods were used to explore wellbeing in a multi-dimensional fashion, capturing subjective and objective dimensions, individual and societal levels, and processes and outcomes. Objective measures were used to capture people's material circumstances, such as income and expenditure, through the resources and needs questionnaire. Subjective measures were used to link these material circumstances to people's own appraisals of their lives as a whole, or to their subjective emotional states (WeD, 2005). Gough and McGregor and the WeD team researchers (2007) developed a conceptual framework for researching wellbeing. The framework involves studying a composite notion of human wellbeing 'comprising states or welfare outcomes, adaptive and creative processes over time, and the social location

within cultures and structure' (Gough, 2006:1). Figure 3.3 below places the social human being at the heart of their analysis. The link between individual and societal wellbeing comes through the collective action that makes up society.

Figure 3.3 WeD's Wellbeing framework (McGregor, 2007:337)



WeD used a combination of three frameworks. These frameworks are: the Theory of Human Need (THN) (Doyal and Gough, 1991); the Resources and Profiles Approach (RPA) (Lewis et al., 1991; Lewis and McGregor, 1992) and the WeDQol (WeDQol, 2006). Health is found to be a prominent feature in the three main conceptual frameworks, that is, as a basic need in THN, a human resource in RPA and an important factor for people's quality of life in the WeDQol. Moreover, access to appropriate healthcare is considered an important factor in human health and wellbeing, as was discussed in Chapter 1.

In order to understand people's wellbeing, the three aspects of 'having, doing and thinking' are applied in the frameworks: 'having' for the RPA, 'doing' for the THN and 'thinking/feeling' (or experiencing and reflecting) for the WeDQol. Referring to Figure 3.3, there are three wellbeing outcomes that correspond to these three frameworks: 1) needs met, defined in terms of material, social, affective and cognitive needs; 2) resources commanded, namely material, environmental, human, social and cultural resources and 3) quality of life achieved, consisting of, among other things, subjective wellbeing, life satisfaction and happiness. The processes that generate these outcomes can be seen in the interaction between needs, resources and meaning and are represented by the arrows in Figure 3.3. In order to achieve goals or objectives, people use resources and adjust both their goals and their strategies for achieving them, according to their perceived satisfaction. In addition to the three frameworks above, WeD has focused on the wider impact of structures on human wellbeing at the global community, nation state, community and household levels.

### ***3.2.3 The relationship between wellbeing, health and healthcare***

'Health' and 'wellbeing' are frequently used interchangeably in many places and approaches, ranging from the most basic definitions found in dictionaries, to more elaborate ones found in academic work. Several dictionaries, for example the Oxford English dictionary, the Cambridge English dictionary, and the Britannica Concise Encyclopaedia, define 'wellbeing' as 'the state of being happy and healthy'. Also, in the work of international organisations such as the WHO and the UNDP, health is widely recognised as a vital element of human wellbeing.

Why is health so important? Part of the answer must lie in the recognition that it is a fundamental part of human wellbeing, as it is essential for survival and, more importantly, it is considered by some to be a basic human need (Doyal and Gough, 1991).

Doyal and Gough state:

‘...health and autonomy are the basic needs which humans must satisfy in order to avoid serious harm of fundamentally impaired participation in their form of life’ (Doyal and Gough, 1991:73).

Without good health, human capabilities can drastically deteriorate. McGillivray (2005) pointed out that health indicators, such as health status and health services, are one of the most widely used means of assessing national wellbeing in international comparisons. This is consistent with the results of other studies such as those by Jack (1999), Lercher (2003), and Clarke and Islam (2004) who suggested that the presence of good health is crucial when determining social welfare. Moreover, health indicators (such as life expectancy and infant mortality) are generally used by various well-known organisations like the UNDP. Being healthy is crucial to everyone because it increases our capability to cope with everyday activities, and those who are endowed with good health are able to help others, such as children or the less healthy. Sen (1999) stated that having good health not only raises satisfaction levels and reduces pain, but is also an important factor that allows us to increase the amount of capability and freedom that we have.

According to a broader concept of health, proposed by the WHO in 1998, health is viewed holistically as an interacting system comprising mental, emotional, physical and social components. This definition is not without criticisms, with some arguing that it is an idealistic goal rather than a realistic proposition. For example, it has not been made clear how this positive conception of health might be measured (Caplan et al, 1981; Doyal and Gough, 1991). However, it is possible to measure the absence of health and Doyal and Gough (1991), for example, suggested that health can be defined and measured negatively as the minimisation of death, disability and disease.

Although health has been widely recognised as a vital element of human wellbeing, the linkage between healthcare and health status is a controversial issue. However, healthcare remains one of the important factors influencing people's health and wellbeing, thus access to healthcare is regarded as a significant input into people's health (Evans et al., 1994; Doyal and Gough, 1991). According to Doyal and Gough's Theory of Human Needs (THN), access to an appropriate healthcare service is one of the intermediate needs of human beings (Doyal and Gough, 1991). Doyal and Gough (1991) explained that these intermediate needs are related to satisfaction. While needs are considered universal, satisfiers of these needs depend on the culture and the society in which the individual is living. For example, people consume healthcare services in order to satisfy their basic need for health which in turn enables their social participation.

According to the WHO (2000), healthcare includes all the goods and services designed to promote health, including 'preventive, curative and palliative interventions, whether directed to individuals or to populations' WHO (2000:6). Nonetheless, most understandings of healthcare remain restricted to the medical arena, which emphasises the role of doctors, nurses and other health professionals. Therefore many healthcare evaluations are assessed using biomedical criteria, and one of the main critiques of the biomedical model is that it ignores human beings (see for example Chuengsatiansup, 2003). The three main disadvantages of the biomedical model's concept of health, according to Chuengsatiansup (2002), can be summarised as follows:

1. The concept has a partial approach which examines life with a clear separation between body and mind, which may not relate to people's experiences or make sense in non-Western cultures. For example, the body is seen as a system consisting of organs and illness is the result of malfunction in some parts of the body. There seems to be no need to link illness with other factors outside of the body.
2. A segregated approach neglects some phenomena that are related to health, such as social factors. The only concern is the biomedical dimension.
3. The causes and effects of illness are explained using a scientific mechanism approach that focuses on biochemical and stringent physical factors, without acknowledging people's feelings or other factors.



Chuengsatiansup (2002) argued that these approaches affect the treatment of patients, which could be seen as evidence that physicians ignore social, spiritual, and human issues, even though these issues would appear difficult to ignore as humans are social beings and have emotions and feelings, and which, unlike a machine, cannot be taken apart to be repaired. Moreover, a lack of social and human dimensions in the biomedical treatment of patients fails to allow physicians a proper understanding of patients' minds. Therefore, the development of a new dimension to the healthcare system, according to Chuengsatiansup (2002), should include the following:

- promoting the importance of self-care;
- learning how to take care of oneself and members of one's family, as well as people in one's community, before, during and after one is sick;
- learning how to have good mental health, which pertains to understanding satisfaction and satiation;
- creating an environment for good societal health (one where there is little or no discrimination or segregation and one where no one is taken advantage of); and propounding the concept of spiritual health, which would allow a person to develop into a more complete human being.

In the above it is clear that health is a broad concept in terms of the physical, mental, social and spiritual, and it can be considered as having both objective and subjective dimensions. Moreover, people's ideas of health and wellbeing may vary according to their circumstances and that there are various ways to maintain and improve one's health. Therefore, an appropriate healthcare service can be used to improve the quality of people's lives and thus contribute to their wellbeing.

In addition to health, the wellbeing literature suggests that 'security' is one of the key indicators of human wellbeing (see for example Doyal and Gough, 1991; Amartya Sen, 1999; Alkire, 2003; Gasper, 2005; Wood, 2007). Doyal and Gough (1991) discuss human security in terms of economic security. When people have no security in life, serious harm can occur, as explained by Doyal and Gough (1991): 'an unacceptable decline in someone's standard of living, where 'unacceptable' refers to a threat in their capacity to participate in their form of life' (Doyal and Gough, 1991:211).

Wood (2007) further suggests that the issue of security is particularly significant for those who are the most underprivileged (Wood, 2007). Wood proposes the notion of ‘risk averters’ as a measurement of human wellbeing. Wood (2007) points out that:

‘It recognises the poor people are especially differentiated from richer people with respect to a sense of security because they face greater uncertainty and discount the future to greater extent. A feature of their ill-being is the fear which arises from not being able to control or significantly influence their immediate or longer term operational environment for survival.’ (Wood 2007: 131)

With regards to healthcare evaluation, it is necessary for evaluators to consider broader methods for assessing a healthcare scheme. A wellbeing approach offers a way forward because it proposes a more holistic way of understanding a healthcare scheme by recognising the subjective, objective and social dimensions of healthcare. This thesis argues that such an approach should be included in the UC evaluation in Thailand. Recognition of the ‘security’ dimension is also useful for identifying the wellbeing of people in terms of health and healthcare, in particular those who have limited resources and alternatives, such as the poor, who are faced with greater uncertainty than richer people when they are sick and unable to gain access to a healthcare service.

### **3.2.4 Wellbeing and health in the Thai context**

The notion of wellbeing has become increasingly popular in Thailand, variously translated as ‘*Kin Dee Yuu Dee*’, ‘*Yuu Yen Pen Sook*’, ‘*Sookka Pava*’, ‘*Khwarm Pha Sook*’ (and more). However, the term ‘*Kin Dee Yuu Dee*’ is likely the most well-known one, literally meaning ‘eat well, live well’. Since the eighth national development plan (1997-2001)<sup>24</sup>, more stress has been placed on ‘people-centred development’ rather than economic development and the meaning of wellbeing has evolved to be that of ‘*Yuu Dee Mee Sook*’, translated as ‘live well, be happy’ (National Economic and Social Development Board of Thailand, NESDB, 1997). Wellbeing, as defined by the NESDB, comprises seven key aspects: 1) health 2) education 3) employment 4) income and income distribution 5) family life 6) environment and 7) good governance. The

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<sup>24</sup> Thailand is currently under the tenth national economic and social development Plan (2007-2011).

health component is an important factor in Thai society owing to its place in Thai belief and culture. A traditional Thai proverb that is used to represent the importance of having good health is ‘*Khwarm Mai Mee Rok Pen Lap An Prasert*’ translated as ‘lack of disease is precious luck’. The NESDB has used a variety of indicators to measure wellbeing and an example of the NESDB’s health indicators is given in the following table.

Table 3.1 NESDB Wellbeing Indicators

Index	Target	Indicator
Health	Long Life	Average age of people
	Good health	Proportion of people who are not sick each year
	Equal distribution of services	Proportion of people with health insurance

Source: NESDB (2006)

Recently, there have been a considerable number of both international and national organisations and scholars who have attempted to research wellbeing amongst the Thai people. For instance, organisations such as: the ESRC Wellbeing in Developing Countries (WeD) Research Group, the Health System Research Institute (HSRI) of Thailand, and scholars including: Mee-Udon and Itarat (2005), Guillen-Royo and Velazco (2006), Jongudomkarn and Camfield (2006), Jongudomkarn (2006), Camfield *et al.* (2007) and Camfield (2009).

Mee-Udon and Itarat (2005) analysed seven major causes of change in Thai female and male wellbeing throughout the 20<sup>th</sup> century. These seven factors are: 1) demography; 2) economic; 3) education; 4) family status and structure; 5) politics; 6) society, health and deviance and 7) religion and culture. According to Mee-Udon and Itarat (2005), the last century has witnessed changing Thai female and male wellbeing in terms of better quality of life, reduction of poverty, and the lessening of the inequality between females and males, as a whole. The quality of life of the Thai people has improved substantially, particularly of females, regarding demography and health. Moreover, Guillen-Royo and Velazco (2006), Jongudomkarn and Camfield (2006), Jongudomkarn

(2006), and Camfield (2006) have all affirmed that health is one of the most important factors in Thai people's wellbeing.

Although wellbeing has featured in the Thai government's discourse and policies as a major goal (see Section 3.2.4), the applications of wellbeing at the practical level are limited. In addition, as mentioned earlier, in Section 1.3.2, although wellbeing has been used in the Thai health sector to capture a more holistic understanding of health, in practice it is still only partially understood (Jongudomkarn, 2006). According to Jongudomkarn (2006) many Thai scholars and health practitioners see good health as a composition of the necessary parts such as physical, mental, emotional, social, and spiritual components and thus ill health is the result of a malfunction in a certain aspect, the correction of which will lead to good health. This partial view of health overlooks the meaning of each aspect for people and, moreover, the relationships amongst these aspects. She argues that a participatory approach is needed in order to fill the gap between the rhetoric and the practice. An example of the partial view can be seen from the NESDB's health indicators as shown in Table 3.1 above, which illustrates how the government is dividing health into little discrete boxes.

In summary, because of the issues outlined above, this thesis will adopt WeD's conceptual framework of wellbeing and use it to develop a new approach to evaluate the UC scheme in the context of Thailand. It is argued that this approach provides a more sustainable wellbeing evaluation tool for a developing country like Thailand, as suggested by Gough (2008). In Gough's view, in order to formulate social policies for sustainable wellbeing for countries/local contexts, according to Gough 2008, the policies should be formulated in three ways.

Firstly, deal with existing informal security accessed through patrons and power-brokers without harming wellbeing in the process.

Secondly, enable and empower the 'broader-based' social movements which will ultimately press for sustainable wellbeing.

Thirdly, 'a dual evaluation' is required in creating social programmes in developing countries. These programmes should meet basic needs and they should empower local people to undertake, analyse and design of their own social policies. In Gough's view

‘These policies must be rooted and grow in local soils’. Imported policies will not necessarily improve wellbeing and will have unintended consequences’ (2008:3)

As the focus of this thesis is to explore whether villagers’ needs are being met, whether they are able to act meaningfully, how satisfied they are with the UC scheme and the contribution of the UC policy to their life satisfaction levels, the linkage between the UC scheme and villagers’ wellbeing will be addressed in the following section. That is to say, a new approach for healthcare evaluation, addressing the wellbeing issue, as well as the methodology problems mentioned in Section 1, will be presented.

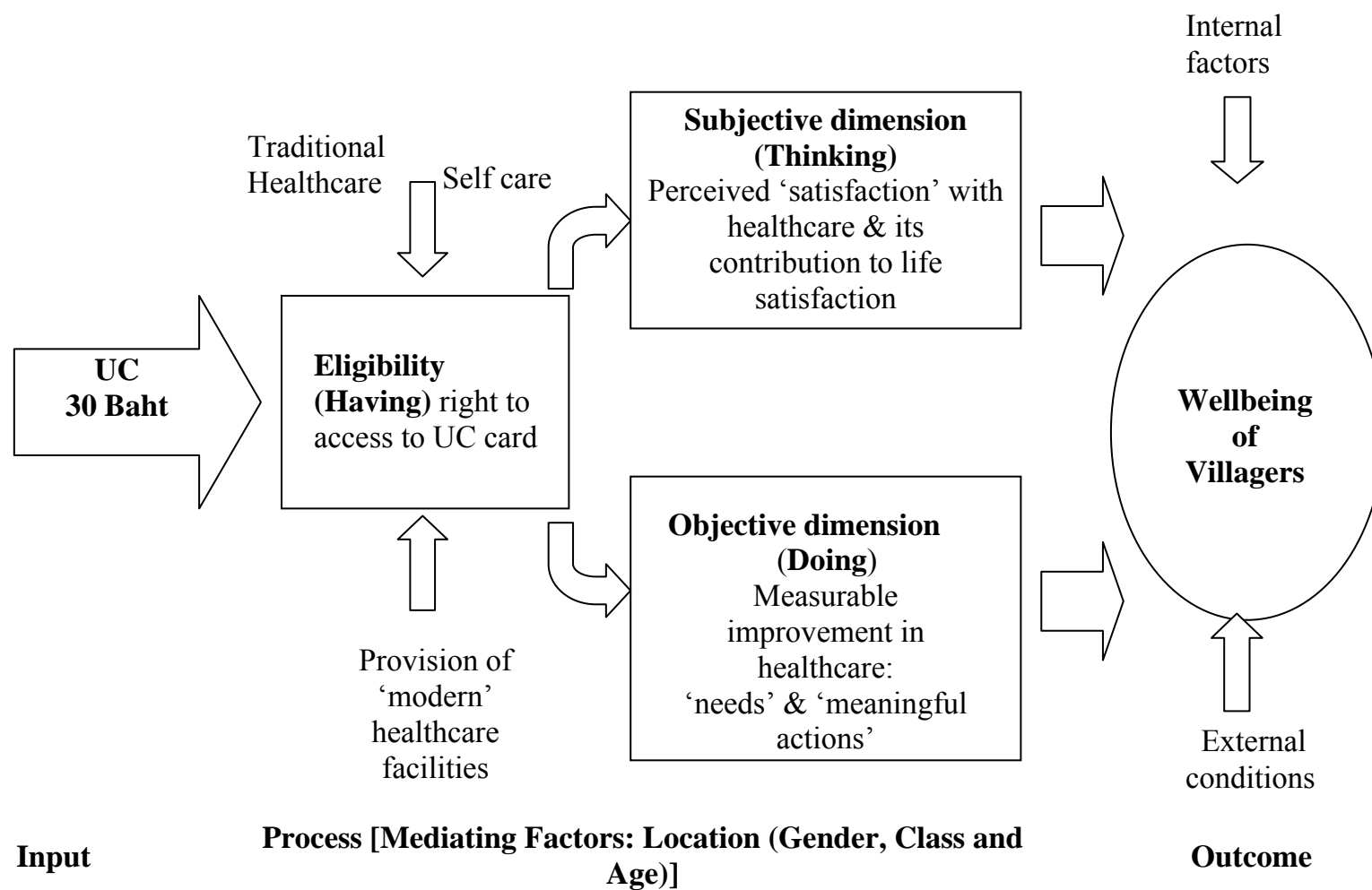
### **3.3 Moving towards a wellbeing assessment**

Section 1 of this chapter outlined conventional healthcare evaluation methods both in general and in the Thai context. It argued for a broader healthcare evaluation to be undertaken from a wellbeing perspective. Section 2 explored the concept of wellbeing in relation to health and healthcare to support the analytical and methodological approach for this thesis. In order to develop a new approach for the UC evaluation, this thesis seeks to address many of the shortcomings of the existing healthcare evaluation methods outlined earlier by adapting the wellbeing framework used by the WeD research group.

Building on the description of the UC scheme and its structure in Chapter 2 (see pages 67 to 69), this section explains how an evaluation of the UC scheme could be carried out from a wellbeing perspective, using a wellbeing-focused methodology. The proposed methodology is Wellbeing Focused Evaluation (WFE), which measures both the subjective and objective dimensions of wellbeing (‘thinking’ and ‘doing’) in relation to internal factors and external conditions (see Figure 3.4, page 125). The principles of a wellbeing-focused evaluation are summarised in this figure, which shows the relationship between the UC scheme and the wellbeing of villagers. It also shows how the process of transforming access to healthcare into wellbeing is mediated by factors such as remote and non-remote location, gender, class and age. As described in the introductory chapter, the WFE built on the conceptual and methodological insights of

WeD, but was developed by the researcher to look at healthcare evaluation in a specific social and cultural context. Although the conceptual basis for the WFE is the WeD understanding of wellbeing, the researcher developed and applied a suite of tools to focus on a specific healthcare intervention. In this way the WFE is distinct and yet builds directly on WeD.

Figure 3.4 A wellbeing focused evaluation (WFE)



According to the WFE approach, there are three main components of the scheme that need to be analysed:

- The content of the UC scheme
- The process of implementation
- The outcome

#### *The content of the UC scheme*

The UC or 30-Baht scheme is seen as an input to the existing healthcare system in Thailand. The healthcare system includes both ‘traditional’ healthcare, for example, massage, and the provision of ‘modern’ healthcare facilities. The former is mainly provided by the people themselves and the latter by the government and the private sector, through a wide range of initiatives. Although both types of healthcare play a role in people’s management of their health, this thesis focuses on the UC scheme (see Chapter 2 for a description of its content) as part of the formal healthcare provision.

#### *The process of implementation*

This describes the implementation of the UC scheme, identifies emerging differences in access, use and perceptions of the scheme, and explores their relationship to the cross-cutting categories of location (remote and non-remote), gender, class and age. The WFE is used here to understand how different people have different abilities to use the UC scheme. The integrated methodological toolkit outlined in chapter 1 is applied to gain a holistic understanding of the UC scheme’s effect on villagers’ wellbeing in terms of needs met, meaningful actions and satisfaction with life (see Chapter 4 for methodology and Appendices for the tools).

#### *The outcome*

The ultimate goal of the UC scheme is to increase the wellbeing of villagers (NHSO, 2007). However, because villagers’ wellbeing outcomes are also influenced by internal factors and external conditions, these need to be taken into account in any evaluation.

Internal factors are mainly related to the villagers’ circumstances (i.e. whether they live in a remote or non-remote area), characteristics such as gender, and cultural values. Cultural values are rarely discussed in conventional evaluations, despite their influence on villagers’ wellbeing, and in particular their satisfaction with life. Their importance is exemplified by the ever present concepts of ‘*Por Jai*’ and ‘*Kreng Jai*



which will be discussed in greater depth in this chapter (page 134), in the next chapter (page 155) and in the section on satisfaction (see Chapter 7 page 240).

External conditions are related to the state, for example, government policies such as the introduction of the UC scheme, the market and the civil society.

By acknowledging the influence of internal factors and external conditions, evaluations of healthcare can move from a narrower perspective that focuses on health outcomes such as changes in health status, to a broader conception that embraces wellbeing. For example, the WFE can be used to assess villagers' wellbeing according to their own criteria, established from qualitative data collected during fieldwork (see Chapter 6 and 7). Some examples and a case study are provided in the thesis to support the argument that the proposed method could potentially provide healthcare policymakers with additional information about the impacts of the UC scheme on villagers' wellbeing.

This research adopts WeD's definition of wellbeing, which considers people's objective circumstances, subjective perceptions of their conditions and relationships with others. This definition emphasises 'conditions' for the pursuit of wellbeing in two areas, as detailed by McGregor (2008): the significant role of the government in creating appropriate conditions; and the fact that these wellbeing conditions are different in each society as they are involved with different stages of development.

This hybrid notion of wellbeing could therefore be measured in different ways, for example, through subjective and objective dimensions, at individual and societal levels, or as both processes and outcomes. In this study, the WFE approach is developed and used to analyse the wellbeing of villagers in relation to the UC scheme focusing on the objective, subjective and relational dimensions. The objective dimensions are measured by investigating the level of uptake and utilisation of the UC card, drawing on data from the researcher's questionnaires and WeD's Resources and Needs Questionnaire (RANQ). The subjective dimensions are measured by perceived satisfaction levels (collected in the researcher's questionnaire) and an assessment of the contribution of the scheme to villagers' lives as a whole drawn from in-depth interviews and other qualitative investigative processes such as participant observation and conversation. Although questions about villagers' levels of satisfaction are used in the researcher's questionnaire, the answers from these form only one part of the analysis. The majority of the data on the satisfaction of the villagers is qualitative and forms the main part of

this analysis. The qualitative data enables investigation of villagers' feelings and their own explanations of how satisfied they are with the UC scheme and how the UC scheme has contributed to increases in their wellbeing, for example, through better living conditions. The relational dimensions, for example, the broader societal processes that people are embedded within, are explored using the multi-method approach outlined in Chapter 1 and explained in greater detail in the next chapter. This approach involves various research tools which can be used for different purposes and applied in different contexts. For this reason it is the most helpful approach to gain a holistic understanding of villagers' wellbeing.

To evaluate the impact of the UC on villagers' wellbeing, the thesis questions are set out as follows:

1. Do the villagers who are eligible for the UC scheme have the UC card?  
Who has the card and who does not and why?
2. Are the villagers who have the UC card using it?
  - 2.1 If so,
    - 2.1.1 What is the level of UC utilisation by the villagers?
    - 2.1.2 How does this differ between different types of people, e.g. non-remote and remote, gender, class and age?
  - 2.2 If not, why not?
3. Has the UC improved villagers' wellbeing?
  - 3.1 If so, in what ways has it done so?
    - 3.1.1 Do they obtain their healthcare needs?
    - 3.1.2 Are they able to act more effectively in pursuit of their healthcare goals?
    - 3.1.3 Do they report a better quality of life as a result of the UC scheme?
  - 3.2 If not, why not?

To answer the questions above, three aspects of life are investigated: needs, meaningful actions and satisfaction with life. From these, three types of observations about the villagers' experiences in the process they engage in with the UC scheme (i.e. their uptake and use of the UC scheme) are employed, namely, the processes of 'having, doing and thinking'.

In order to investigate whether people are meeting their needs as a result of using the UC scheme, the THN and the RPA are applied. The THN is employed to understand

the importance of health and healthcare from the villagers' point of view and to analyse how the UC scheme is appropriate for the villagers' health needs. Following Doyal and Gough's Theory of Human Need (THN) (1991), health and autonomy are basic needs for all of humanity. This means that health and autonomy are important for all and if an individual lacks these, she/he will suffer serious harm, which significantly impairs the achievement of their goals. With regards to healthcare and its relation to needs, Doyal and Gough (1991) suggested that access to appropriate healthcare is one of the intermediate needs or 'needs satisfiers' that contribute to the achievement of optimum levels of health. Hence the achievement of health and autonomy can enable individuals to participate in social activities.

In addition to the THN, this study uses the RPA to explore which resources the villagers are able to command in order to meet their needs, or in other words, the resources that villagers *have* or *do not have*. There are five main categories of resources: material, human, environmental, social and cultural. One key objective of the UC scheme is to reduce inequities of access to healthcare services by providing equal access to uninsured Thai citizens regardless of socio-economic status. In this respect, villagers who were selected as case study respondents were all eligible to participate in the UC scheme (Chapter 4). On this basis, it is assumed that villagers are provided with equal opportunities to receive healthcare services, regardless of location, gender, class and age. Therefore, it is important to find out whether these eligible individuals have the UC card.

Secondly, in order to understand villagers' meaningful actions in relation to the UC scheme, it is necessary to explore their reasons for possessing and using the card. Once the resources that people have are established, it is then important to explore what people *do* or *do not do* with these resources, in achieving their goals. When the UC scheme is available as a resource for accessing healthcare, it is necessary to explore how people act or what they do with it. Therefore, 'utilisation' of the UC card is considered to be another important indicator for understanding the villagers' meaningful actions taken in pursuit of their health goals. To address this point, this study employs the concept of 'meaningful actions' used in the WeD framework. According to WeD (2007), people's goals influence the actions they take to attain them, and for this reason the actions can be described as 'meaningful'. Both the goals and the actions are greatly influenced by the material, social and cultural contexts in which the people are

embedded, at family, community, national and international levels. For instance, in communities where there exists a shared aspiration to be healthy, people are more likely to be encouraged to exercise and eat healthily. Thus, in order to be able to understand individuals' goals and actions, i.e. which actions are considered meaningful and why, it is crucial to consider their socio-cultural contexts.

Moreover, WeD (2007) indicated that individuals possess different identities, which are influenced by age, gender, belief systems, and personal histories. These distinct identities are crucial, given that they can shape individuals' needs and wants. For instance, although everyone is aware that good healthcare access contributes to being healthy and to a longer lifespan, it is not always attainable. For example, according to Nussbaum (2000), in Indian society, women have less access to the healthcare system than men and perhaps related to this is the finding that women's and girls' death rates exceed those of men and boys across all age groups up to people in their late thirties.

The WeD (2007) researchers argued that wellbeing cannot be considered merely from an objective and subjective perspective, but also requires a social or relational perspective. This is supported by Schaaf (2007), who found that the notion of relatedness is central to constructions of villagers' wellbeing in Thailand. Even though people usually act according to social norms, there are some situations in which collective rules are not respected, such as when someone breaks the law. Furthermore, according to WeD (2007), the different forms of relationship in which individuals are embedded offer varying opportunities or choices for people with different goals and identities. Moreover, these opportunities also vary in relation to the social and individual factors mentioned above. Therefore, the researchers proposed that people always engage in meaningful actions given that they usually behave according to their values, goals and identities, which may vary from individual to individual.

When individuals are meeting their basic needs, according to the THN, for example if they have 'good health', it enables individuals to be able to make and act on informed choices. For example, when people are healthy they can perform valued activities such as attending the temple or 'making acts of merit' and when they are autonomous they are in control of what they are willing and wanting to do. Therefore there is an emphasis on the connection between basic needs and meaningful actions, which forms the focus of this thesis.

The concept of meaningful actions can also be explained using Sen's capabilities approach (1993; 1999) which states that people's choices depend on their circumstances and capabilities. Sen (1999) proposes that each person should have the freedom to select and take part in development programmes both as an individual and as a member of a group, provided that their actions do not infringe upon the rights of other people or groups. This perspective is underpinned by the assumption that individuals always have a choice and that they should be the ones who initiate the development process. Sen further suggests that the state should provide more opportunities or better circumstances for increasing citizens' capabilities, so as to allow them to fulfil their choices and the development of individual capabilities that can contribute to society. Likewise, McGregor (2008) points out that the pursuit of wellbeing can be achieved through 'conditions' that have been put in place. In this way, when the UC scheme has potentially provided wider choices and good conditions for the villagers, the questions that arise are: whether they take up these choices and what are the reasons for their meaningful actions.

Returning to this thesis and the study of the UC scheme, it emerges as particularly important to investigate the reasons for people's uptake of and use of the UC card. It may be the case that for some people, use of the UC card is not related to their access to it and, rather, it may be related to the individuals' perceptions of quality of care and their identities and personal circumstances, such as: gender, class, age and location. Moreover, use of the UC card might be shaped by the material, social and cultural contexts in which people are embedded by socialisation processes. For instance, villagers who live in a remote community might have a greater tendency to use traditional healthcare or self-care than those who live in non-remote areas.

The last concept to be discussed for this wellbeing focused evaluation is that of life satisfaction, which people derive from meeting their needs and acting meaningfully to pursue their goals. This suggests that there needs to be an emphasis placed on how people judge, assess, and feel about the contribution of the UC scheme to their life satisfaction, in terms of the outcomes achieved. In order to understand life satisfaction, WeD developed the WeD-Quality of life framework (WeDQoL), which studies how satisfied people are with what they have, and what they can do and be, as well as what they think and feel about what they have and do, according to their own self-evaluation (WeD 2006). The QoL originates from within the discipline of psychology and the substantial amount of literature that has been applied to this field. Ryan and Deci's self-

determination theory (2000) argued for the importance of psychological needs as a significant aspect of individual wellbeing and posited three basic and universal psychological needs: autonomy, competence and relatedness. WeD used this theory as one way to frame the WeD Quality of life framework. Another source was Ruta (1998) who developed the Personal Generated Index of Quality of life (PGI)<sup>25</sup> to produce an individualised quality of life and wellbeing measure. WeD adapted this tool to research the satisfaction of villagers in WeD's four research countries, one of which was Thailand.

This thesis applies the WeDQol and the PGI<sup>26</sup> to study the villagers' life satisfaction levels. They are suitable because they can be used at either the individual or the community level. It has to be noted that, according to the WeDQol, good feelings, satisfaction or hedonic happiness are affected by aspirations and adaptive preferences, so this is considered to be likely to change over time. Therefore WeD advocated using a combination of various dimensions to study wellbeing in different aspects, from objective, subjective, individual and relational perspectives and in terms of processes and outcomes.

However, as discussed with regard to processes, this thesis is constrained by time, so under these circumstances adaptive preference is not an easy issue to examine. Thus the satisfaction of the villagers in this context will be taken as that pertaining at one point in time, i.e. when the study was undertaken.

With regard to satisfaction in relation to the UC scheme and to villagers' lives as a whole, this study uses the WeDQol in order to identify the self-evaluation made by the villagers, and the interpretation additionally seeks to combine the WeDQol framework with the Buddhist point of view in order to achieve a richer understanding of the relevant issues.

The substantial contribution of the WeDQol notwithstanding, it is still necessary to know how the concept is understood by the Thai people in order to estimate the villagers' satisfaction levels. Therefore, a grasp of the meaning of satisfaction from the Buddhist point of view is essential. This is because in Thai society experiencing satisfaction is highly valued and consequently the use of the term is somewhat different

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<sup>25</sup> This will be discussed in detail in the methodology sections (Chapter 4).

<sup>26</sup> This will be discussed more in Chapter 4.

from its use in modern Western economics, where it denotes a degree of consumer evaluation.

The word 'satisfied' can be translated as '*Por Jai*' in Thai, literally meaning 'enough (for the) heart (to be happy)'. The meaning of '*Por Jai*' or contentment can be explained by drawing on the spiritual tradition active within Thailand. There is a teaching in Buddhism that recognises that, to be satisfied, which is translated as 'contentment with whatever is one's own' (Phra Dhammapidok 1995:125), is a way of overcoming the dissatisfaction that derives from human passions. To reduce their mental suffering, in this case that coming from unsatisfactoriness or dissatisfaction [*Dukkha*], the act of being satisfied or contented with whatever they have, is an important part of life for Thai people.

According to P.A Payutto (1994), satisfaction in Buddhist economics is very different from that found in modern economics: the former sees satisfaction in terms of balancing between material wellbeing and spiritual value, whereas the latter focuses more on a maximisation of satisfaction from the consumption of material goods. In other words, satisfaction in Buddhist economics is closely related to spiritual values and is not necessarily associated with consumption; sometimes satisfaction can be achieved by having few desires and consuming less. Other well-known and powerful books written by modern economists, which take a similar stance are 'Small is Beautiful' (Schumacher, 1973) and 'Development as Freedom' (Sen, 1999). The core ideas of these books seek to realise human liberation and freedom rather than materialism and consumption.

In order to be satisfied with life, according to P.A Payutto (ibid), Buddha taught people to consider '*Mattannuta*', which is the *Pali* word for knowing moderation. '*Mattannuta*' is explained by Pra Dhammapidoka, as 'knowing the right amount in the use and consumption of material things, in speech, work and action, in rest and leisure' (1996:2). According to P.A Payutto (1994) satisfaction can be attained from finding a middle way between 'too much' and 'too little'. In his view:

'*Mattannuta* is the defining characteristic of Buddhist economics. Knowing the right amount in consumption refers to an awareness of that optimum point where the enhancement of true well-being coincides with the experience of satisfaction.' (1994:39)

In the Buddhist system P.A Payutto (ibid) describes consumption as a balancing point between satisfaction and quality of life, where goods and services are used to answer wants and needs in ways that create satisfaction through having quality of life.

Satisfaction expressed in the Buddhist way therefore has a significant impact on how people feel and think and act<sup>27</sup>. Support for this proposition is found in the literature on happiness and wellbeing, in which Gray *et al* (2008), for example, suggest that happiness is part of the Thai character. In their view, the finding of happiness amongst the Thai population 'is likely to reflect the modest self-presentation influenced by Buddhist teaching of avoidance of the two extremes of happiness and sadness' (2008:84). One obvious example of modest self-presentation, is the emphasis on keeping smiling and calm. This leads to Thailand being described by tourists as 'the land of smiles' (see, for example, Hughes and Leethongdee (2007) *Universal Coverage In The Land Of Smiles*). This practice is also believed to be linked to Buddhist culture.

Together with the national religion of Buddhism, the monarchy is an important influence on development and social policy in Thailand. As mentioned earlier, the King's speech on 'a sufficiency economy' was adopted as a core concept in building the Thai health system. This idea has become increasingly seen as a way of living among villagers because most Thai people have high respect for the King and his message. The core idea of this is to suggest to Thai people to exercise restraint or measure what is needed in life in order to decrease unnecessary consumption. Thus, in this way, the King's speech can be considered as closely following the Buddhist form of economics.

This last section (Section 3) has explained the way in which the WeD approach is used in this thesis to form three lines of inquiry: what people have, what they do, and what they think about what they have and do. It recognises that wellbeing comprises various aspects: objective, subjective and relational, and that it is also related to people's social and cultural contexts. Hence, in order to evaluate how the UC contributes to people's wellbeing, a broader approach, which uses a more holistic view as advocated by a wellbeing focused approach, is proposed.

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<sup>27</sup> The role of Buddhism in leading to happiness and satisfaction has been well explained by many philosophers and scholars. See, for example, Dalai Lama H.H. and Cutler H.C. (1999); Ricard, M. & Goleman, D. (2003) and Tashi, K.P. (2004).



### 3.4 Conclusion

This chapter has reviewed the relevant literature and approaches to the evaluation of healthcare provision. It is argued that the conventional approaches to healthcare evaluation require considerable modification as they need to be adapted to the changing policy and political environment of Thailand.

Recently, Thailand has undergone many changes, in that a new healthcare system has been implemented and the meaning of health itself has expanded from a narrow concept to a broader term, equivalent to that of wellbeing. More importantly, wellbeing has been identified as an ultimate goal for the UC scheme. This thesis argues for the development of evaluation tools that draw on a broader approach than that of traditional evaluations, which are limited in terms of conceptualisation and methodology.

This thesis proposes a new approach to evaluation, 'Wellbeing Focused Evaluation (WFE)', to evaluate the impact of the UC scheme on the wellbeing of villagers in Northeast Thailand. The WFE approach is adapted from the 'Wellbeing in Developing Countries' conceptual models, as proposed by Gough and McGregor (2007) and the WeD project (2007). It is argued that the use of a WFE approach to evaluate the healthcare system in Thailand offers a better understanding of wellbeing among villagers in three aspects: in relation to human needs being met, how one can act meaningfully to pursue one's goals, and experiences of a satisfactory quality of life.

The next chapter describes the methodology used in the WFE and in this thesis.



## **Chapter 4: Research Methodology**

In the preceding chapters, the rationale, concepts and a new approach for evaluating the extent of the UC scheme's contribution to villagers' wellbeing were established. This chapter discusses how these concepts and approach were put into practice within the research sites and provides a critical account of the research methods chosen for the study. The focus on villagers' wellbeing, which involves objective, subjective and relational dimensions, and the inadequacy of evaluation approaches in the Thai healthcare system, suggest combinations of methodologies would be appropriate. As discussed in the previous chapter, in order to create a suitable instrument for the Thai healthcare context, this thesis argues for a broader concept of evaluation and proposes a new approach to evaluation, the Wellbeing Focused Evaluation (WFE) approach developed by the researcher. The WFE was developed from the WeD framework; thus some of its methods were applied for researching the villages. As such, the research approach in this thesis employs a multi-method approach comprising both qualitative and quantitative techniques.

This chapter consists of six sections. The first section is the theoretical underpinning of the researcher's choice of methodology. The second section focuses specifically on site selection. The third section describes the process of research and the experiences of the fieldwork. This section includes some reflections on the researcher's overall research experience, which helped the researcher refine the research aim and methodology. Section four looks at the ethical and cultural issues when doing research as well as considering how some of the difficulties encountered were resolved. Section five explains how data were analysed and interpreted. The chapter ends with a concluding discussion of the overall approach and evaluates the success of the method.

### **4.1 A multi-methods approach**

In order to investigate villagers' wellbeing i.e. needs met, meaningful actions and experience of satisfaction with life, it is necessary to consider the 'hybrid definition' of the term wellbeing. The Wellbeing Focused Evaluation (WFE) approach draws on the WeD framework, which explores the different dimensions of wellbeing, by focusing on the different 'building blocks' of WeD's definition that wellbeing can arise when human

needs are met, a person is able to act meaningfully to pursue one's goals, and when one experiences satisfaction with life. In order to develop a conceptual and methodological framework for understanding wellbeing in developing countries, WeD used a set of research tools comprising a range of methods from both quantitative and qualitative approaches. While using the methods, WeD also adapted them to the particular research context (WeD toolbox). These mixed methods were applied in the WeD research through the following six components: community profiles, RANQ (The Resources And Need Questionnaire), IES (Income and Expenditure Survey), QoL (Quality of life), Process research and Structures and Regimes (Gough and MaGregor 2007)

The research for this thesis considered the multidimensional aspects of wellbeing and used some of the components of the WeD methodology to research wellbeing in the research sites. These included community profiles, RANQ (Resources and Needs Questionnaire), and the WeD-QoL approach. The community profiles describe general information about the WeD research sites in rural and urban communities in two different areas of Thailand: the Northeast and the South. The RANQ<sup>28</sup> is a survey instrument used in the WeD project, whereby individuals within a household are interviewed to ascertain the household's access to a wide range of resources and the need satisfactions achieved. The research for this thesis used the RANQ findings as a source of secondary data to get an overview of the villagers' health status and healthcare access. The RANQ data was also triangulated with the findings of this research. Moreover, the RANQ was used as a baseline dataset to select the sample for this study. This will be explained in greater detail in section 4.3.4.

Furthermore, a WeDQoL-PGI was adapted to construct questions asking villagers about their wellbeing and quality of life. The Person Generated Index (PGI<sup>29</sup>) was developed by Danny Ruta (Ruta *et al* 1994 ) and was initially a type of measurement used for identifying a health-related quality of life of individuals. It was applied in the WeDQoL to investigate villagers' satisfaction with life overall, through asking villagers to identify the five most important things that affect their quality of life (see WeDQoLtoolbox). The PGI index used during interviews with villagers in this research was adapted from WeD-QoL. All respondents were asked to identify five factors that were the most

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<sup>28</sup> See also [www.bath.ac.uk/econ-dev/wellbeing/research/methods-toobox/ranq-toolbox.htm](http://www.bath.ac.uk/econ-dev/wellbeing/research/methods-toobox/ranq-toolbox.htm).

<sup>29</sup> See also <http://www.welldev.org.uk/research/methods-toobox/qol-toolbox.htm/>

important aspects of their lives, and then rate the condition of each factor using the seven pie charts (see Appendix 2).

In addition to the WeD methodologies, a multi-methods approach comprising both qualitative and quantitative techniques was applied. According to Kanbur (2001), there are various debates concerning the strengths and weaknesses of quantitative and qualitative research. For example, the quantitative method implies the use of numbers, which can be more easily aggregated, but it can hide texture, such as in-depth detail that can be derived from the qualitative approach. As suggested by Kanbur, by mutually adapting the two approaches, one can ‘... make the best of complementarities while minimising tradeoffs’ (2001:1). This involves combining the breadth of one and the depth of the other (2001:18).

It is useful to reflect briefly on the philosophy of these two approaches in order to gain better understanding of the nature of each approach. In terms of epistemological approaches, quantitative research is linked with positivism and therefore seeks to apply natural science models to social reality (Bryman 2001). Much emphasis is thus given to understanding reality as an objective and external phenomenon that is observable. From the observations, laws and hypotheses are generated or refuted. In contrast, qualitative techniques are usually linked with interpretive positions. Interpretivism rejects the link between natural and social sciences, and argues that the study of the social world requires specific research techniques such as ‘participant observation’ (Geertz, 1973). Providing background information on people’s lives is necessary to understand their thinking and behaviour. Geertz (1973) refers to this depth of information and understanding as ‘thick description’. According to Geertz (1973), a common observation language is impossible in the social sciences. Geertz writes:

‘man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning’ (1973:5).

The task of the social scientist is to get as close as possible to the reality where individuals interpret the world through their own experiences. That is to say the research methods used in social sciences can approximate reality, but this is not the

absolute reality. ‘Reality’ in social sciences, according to Geertz (1973), has been constructed through the interrelations of human action.

Additionally, because the researcher’s academic background was in social anthropology, which uses qualitative methods to generate data, the focus of this thesis was on the social and cultural context of the villages rather than on generating a model as a means to prove or reject theory. In order to gain information on villagers’ lives, such as their reasons for using the UC scheme and its accessibility, as well as the villagers’ satisfaction with life as a result of the UC’s contribution, it was important to use methods that were geared towards tackling issues of a subjective nature. As such, this thesis is not approaching these issues by testing constructed hypotheses, but rather by allowing the data to dictate the direction of the research.

However, this research also adopted quantitative techniques to assess objective wellbeing with explicit reference to health and healthcare policy. In order to understand information on objective indicators such as the level of access and the use of the UC card by villagers, questionnaire surveys were distributed to individuals in each household. In addition, information from villagers in each household was used to explain the characteristics of the community, traditions, and the health seeking behaviour of villagers in non-remote and remote areas. This research therefore applied a multi-methods approach as used in WeD (Gough and McGregor 2007) and described by Kanbur (2001).

## **4.2 Selection of research sites**

The site selection in this research was directly influenced by the researcher’s involvement in the WeD research project. While the researcher was working with the WeD KKU team (the Khon Kaen University WeD was one of the research teams for the WeD project based in Thailand) for research on three sites in the Northeast of Thailand, the researcher decided to use two of them for this thesis. The researcher chose the most remote site and a site closer to Khon Kaen in order to explore the importance of differences in their social and cultural backgrounds. The remote/non-remote criterion is important as there is evidence that people in the latter tend to benefit more from healthcare facilities than those in the former (Na Ranong, 2003). Previous studies have

also found that location influences the extent and form of access to healthcare resources (ibid 2003; RANQ 2004). Both sites used in this study had a medium population size (approximately 100-200 households) and this made them very suitable. This is because the researcher PhD procedure does not allow the researcher to spend a lot of time doing fieldwork.

Although one of the sites is more remote, both are rural. This reflects the fact that the majority of Thais live in rural areas. A report from the Institute for Population and Social Research shows that although urbanisation is taking place in Thailand, more than 60 % of the Thai population is still living in rural areas (IPSR 2009). Therefore, these villages were suitable for carrying out this research as the majority of the UC users live in rural areas. The first village in this study is close to the city (also called '*Baan non-remote*' see section 4.4 for a discussion of confidentiality and anonymity). This village could be classified as semi-rural or peri-urban. Its location has led villagers to benefit from more employment opportunities outside the village. Villagers in *Baan non-remote* are close to many services and healthcare facilities available in the city. The second village, or *Baan remote*, is located in a more remote area and thus its villagers may be expected to have different experiences of accessing the facilities and using healthcare services compared to the first village.

### **4.3 Process of the research and the relation of the researcher to the field**

The research process began with finding 'a main research question', which came about by reading and discussing ideas with the researcher's supervision panel. Throughout this process, there was considerable iteration with intellectual developments at WeD. The research questions were produced based on insights the researcher obtained from relevant literature reviews (see Chapter 2 and Chapter 3).

It is common for researchers to find that their research plans do not always proceed sequentially. This is certainly true in this thesis. New ideas also emerged during fieldwork trips that obliged the researcher to engage with issues that were not obvious at the beginning. Although the possibility of change was a normal occurrence in the research, the researcher tried to ensure that it did not divert from the original research objective. For example, in the researcher's original proposal, the research focused

particularly on gender issues in the healthcare contexts. This was due to background reading and initial observations that suggested there was gender inequality in terms of access to healthcare (Chapter 2). In addition, the researcher wrote an article on Thai female wellbeing using the existing statistical data. The article demonstrated that according to statistics, more females benefit from healthcare than males (Mee-Udon and Itarat, 2005). However, data from the first round of fieldwork showed that economic class and age also influenced villagers' access to healthcare resources as well as their healthcare seeking behaviour.

Prior to this, the researcher already had some research experience in Northeastern Thailand. The researcher completed a postgraduate degree in community development from Khon Kaen University and subsequently worked there as a lecturer from 1991, therefore was able to understand and communicate with local people in the *Isaan*<sup>30</sup> language: a key advantage when conducting research in this region. The researcher carried out research in *Baan* non-remote that contributed to an MA degree in 1996. The researcher was therefore already familiar with the village and this subsequently helped during the PhD fieldwork. In addition, as mentioned earlier, the researcher's involvement with WeD since 2003 allowed the researcher to combine the knowledge of the research sites with the new ideas learned from WeD. These experiences and established contacts gave the researcher confidence to work in these research sites. At the start of the research in 2004, preliminary explorations were made with WeD KKU to find out whether people in the sites would welcome the researcher's research. In addition, the researcher also met with the UC policy makers both in Bangkok and in Khon Kaen to ascertain the possibility of cooperation.

#### **4.4 The Fieldwork: Method of data collection**

The actual fieldwork was undertaken in two stages over a total period of eight months. The first stage started in October 2004 and ended in March 2005. During this time, the researcher spent approximately three months in each village. The second stage took place from October to November 2005. The qualitative elements of the research were

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<sup>30</sup> It is also known as Esarn or Isarn. This refers to the northeast region of Thailand, where the research sites are located and most people use *Isaan* or Lao, the local language, for communication (see Chapter5).



conducted in accordance with the following five principles<sup>31</sup>: Firstly, the most important principle for a researcher when collecting data is to be open-minded. Secondly, there must be consideration of the ‘insider’ and ‘outsider’ concepts, particularly when focusing on participants’ perspectives. Thirdly, it is important to understand villagers’ culture and to interact with them in a respectful manner. The fourth involves creating a friendly and informal atmosphere and building up good relationships with the villagers. Finally, one must analyse the data inductively and pay attention to its detail.

These principles are important, according to Samuttkup 2005, and appropriate for this study for the following reasons; first, the nature of this research involves people’s wellbeing in their contexts. The study thus requires of the research process that it understands the relationship between people and their contexts. Since this relationship is frequently complicated, it is suggested that the researcher should be prepared for the problems and challenges that may occur in the field. An open-minded and flexible approach is an important in dealing with some of those ‘unexpected’ issues.

Second, researchers differ from villagers in many aspects. As an ‘outsider’, the researcher should learn how to respect local cultures. Observing local codes of behaviour may help the researcher to avoid being misunderstood. From the researcher’s experience, many villagers are very happy to invite a researcher as their ‘guest’ to join them in eating and drinking. Denying this invitation may cause villagers to feel unfriendliness together with a lack of respect coming from the researcher. In some situations the researcher should also be aware of over drinking alcohol, so for this reason it is suggested not to drink with villagers. In summary, researchers should attempt to adjust to the lifestyle of the villagers they work with and conduct their research accordingly.

Lastly, as the main focuses of this study are wellbeing and healthcare, which involves villagers’ experience of healthcare, a friendly and relaxed conversation will allow villagers to describe their situations rather than a formal interview. Samuttkup (2005) further emphasises that relationships and social interaction between researcher and

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<sup>31</sup> These come from a training session in January 2005 organised by WeD KKU with Ajarn Suriya Samuttkup a Thai anthropologist who is highly experienced in conducting research in the Northeast of Thailand and is formerly a lecturer at KKU.

villagers are as important as data. In anthropology, the researcher is considered as the primary instrument and in-depth interviewing usually enables close contact between the researcher and the people being studied. From the researcher's experience, this has proved to be the case that when the researcher interview the women. In addition, as discussed in Chapter 3, the nature of the large-scale survey has limited potential that is relevant to people's experiences and personal explanations of their everyday lives. In order to understand how wellbeing is perceived through the villagers' eyes, researchers should pay attention to their own social and phenomenological circumstances.

In summary, the quality of the principles from a qualitative approach mentioned above is appropriate for this study because it offers a better opportunity for researchers to gain a better understanding of villagers' health and wellbeing in their particular context.

In terms of quantitative data, questions based on the objectives of the study were devised in order to objectively measure the villagers' wellbeing.<sup>32</sup> The first draft of the questionnaire was then piloted in a village close to the main research area and in which the UC had also been implemented. Pilot interviews were carried out with 10 villagers. The purpose of the pilot study was to investigate whether the questions prepared were understandable to the interviewees. The pilot exercise highlighted the appropriate questions but also helped the researcher and the research assistants to become familiar with the questions. Moreover, it provided insights into how the UC scheme is implemented in different village contexts. After the pilot interview, the content of the questionnaires was finalised. The revised questionnaires consisted of seven parts:

- 1) Personal Information
  - 2) General Ideas about Wellbeing
  - 3) Health and Wellbeing
  - 4) Personal Experience with Using the UC
  - 5) Knowledge About the UC
  - 6) Satisfaction with Using the UC and
  - 7) General Ideas about gender and Health
- (for more details see Appendix 2).

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<sup>32</sup> My special thanks go to Dr. Dusadee Ayuwat a member of WeD's KKU at Khon Kaen University for her valuable comments on the questionnaire design.

In order to identify how satisfied the villagers were with the UC scheme, they were asked about their satisfaction with respect to two aspects: (a) general satisfaction with the scheme and satisfaction with the UC card in comparison with other previous cards (b) specific satisfaction with the UC card (see section six of questionnaire). The question regarding the first aspect was open-ended because the focus was on identifying the reasons for satisfaction and dissatisfaction. The question regarding the second focused on the satisfaction with the UC card in relation to 15 issues including: time consumed, consultation, sufficient doctors and quality of services (see Appendix 2).

During the second stage of the fieldwork, the researcher was again involved in WeD's 'health research project' as a translator. By taking this role, the researcher had a chance to interview people outside the researcher's immediate research area. This opportunity was part of an important learning process and it equipped the researcher with better ideas that were then adapted to the researcher's research methodology. These are explained more in section 4.4 on interviewing 'women's issues'.

A multi-methods approach, using both quantitative and qualitative techniques, was employed to collect data in the field. The quantitative method involved the use of questionnaire surveys. For the qualitative method, two main methodological tools were used: individual in-depth interviews and focus group discussions. The in-depth interviews were employed to interview key informants, including villagers, health workers and policy makers. Participant observation and the researcher's general field notes and diary field notes were also used.

#### **4.4.1 *The interviews***

The researcher and five research assistants conducted a total of 293 interviews in two villages between October 2004 to March 2005 for the first stage and the second stage took place from October to November. Most questionnaires were administered by research assistants, however, most in-depth interviews and focus groups were conducted by the researcher.

As this research involved administering questionnaires and conducting interviews and focus groups in two different locations (see Chapter 5 for research context) it was not possible for the researcher alone to do this within the timescale of the study. The need for research assistants with ability in Thai, Isaan and other local languages was evident

and this study thus employed five research assistants. One assistant was a former student of the researcher from the department of community development at Khon Kaen University. She was a native *Isaan* speaker from rural Thailand who had had experience working as a research assistant in Northeast Thailand. Her experience helped the researcher greatly in terms of collecting data in the *Isaan* language. As in the non-remote village the majority of the population is *Isaan* speaking, the researcher asked her to help the researcher to work in this community. The other four research assistants were villagers from the remote village. As this village consisted of villagers from different ethnic groups who spoke different languages, it was necessary to recruit research assistants within the research site. These were predominantly students, including one undergraduate, from different ethnic groups. They helped the researcher collect data and understand the events and traditions of the different hamlets which comprised the villages. All research assistants were trained by the researcher before administering the questionnaires to develop their research skills and ensure they understood the objectives and themes of the research.

The training had two parts. Firstly, before the research assistants administered any questionnaires, they were given a questionnaire to study and the researcher explained all the questions to them. They were told to feel free to ask any questions if they did not understand. Secondly, the researcher and research assistant piloted the questionnaires beforehand to check that that the respondents had understood the questions. Thirdly, when the assistants returned with the completed questionnaire, the researcher checked the contents to confirm that they had recorded the responses clearly. For an explanation of how the researcher worked with the assistants on the data analysis see section 4.5.

In this research, the interviewees can be divided into two main groups: health administrators and villagers.

### **(1) Health administrators group**

In this group, the researcher interviewed four health workers who were working at the healthcare centre and two policy makers from the National Health Security Office (NHSO) in the Bangkok headquarters and in the Khon Kaen office (see Appendix 3-2).

## (2) Villagers group

For respondents who were villagers data were collected from questionnaire surveys, in-depth interviews and focus groups. The questionnaire surveys and in-depth interviews were used in both villages with an equal number of women and men of different economic statuses and age groups. These were sampled using data previously collected by WeD. However, for one of the focus group discussions the participants were health volunteers and most of them were women; thus there were more female than male interviews (see table 4.1 and table 4.2). It should be noted that although villagers have other types of health insurance, such as the CSMBS, the SSS and private insurance, the sample only included those with the UC card.

Table 4.1: Fieldwork locations and total number of informants

Location	No. of respondents for the questionnaire		No. of participants in focus group		No. of cases in the in-depth interviews		No. of Health care workers	Total
	Man	Woman	Man	Woman	Man	Woman		
Bann non-remote	47	47	10	16	6	6	2	<b>134</b>
Bann remote	61	61	9	12	6	6	2	<b>157</b>
<b>Total</b>	94	122	19	28	12	12	4	<b>291*</b>
	<b>216</b>		<b>47</b>		<b>24</b>		<b>4</b>	

\*Note: This number includes only villagers and healthcare workers in the research sites. But there is some double counting as respondents participated in more than one of these activities.

### *Group A: Mixed focus group for health volunteers*

Given the nature of the research it was essential to talk to a group of health volunteers. The focus group was useful not only to explore general ideas regarding villagers' health behaviour and health care system, but it also provided a 'general introduction' to the research. Meeting these key informants allowed the researcher to build a good rapport with individuals and establish through them links to other social networks. Moreover, information gained from the discussions was used to design the questionnaire and semi-structure interviews (see Appendix 3-1).

*Group B: Separate focus group for women and men focus group*

In order to investigate the actual experience of women and men in relation to the UC's context, women and men from both villages with different age profiles were asked to provide information as key informants. In order to do this, the researcher organised four focus group discussions. These were performed in a gender sensitive way to ensure that both men and women participated equally and felt comfortable to express their opinions. To do this, the researcher decided to carry out separate focus groups for each gender. In addition, the moderators, who ran the focus group discussions, were the same sex as the participants. Semi structured interview guidelines for both the women's and men's groups were applied. The interview guidelines contained questions concerning the context of villagers' lives and concepts relating to wellbeing, health, healthcare and gender (see Appendix 4).

*Group C: In-depth interview with 12 men and 12 women*

The initial analysis of the data from the questionnaires in the first round of fieldwork focused on gender differences. However, it was found that class and age were also important, as villagers of different age and economic class appeared to use the UC card differently (see Chapter 6 on utilisation of UC card). This was also affirmed by the researcher's own observations during the first round of the fieldwork. This led to a simpler system of classifying economic class in the second round of the fieldwork, by dividing the class into two groups: 'the better off' (the rich) and 'the worse off', which involved the uniting of the middle and poor classes from the first round of the fieldwork.

In relation to age, villagers were grouped into three age groups, namely the young (18-25), the middle aged (26-59) and the old (60 or over), which was the same as the first round of fieldwork. The reason for this was that firstly, the average age for marriage for Thai men is between 26 and 27, while women marry at around 23 or 24 years of age (Chayovan 2003). This suggests that 18-25 year olds are young in the sense that they do not have partners or children. Secondly, the retirement age for Thai people is 60, and therefore people who are over 60 years old are usually considered old. In the second fieldwork period, 24 respondents were selected as interviewees; 12 men and 12 women from different economic and age groups within each village (Table 4.2).

Table 4.2: Number and characteristic of key informants

Age / gender	<i>Baan non-remote</i>		<i>Baan remote</i>	
	Worse off	Better off	Worse off	Better off
Young				
18-25 Men	1	1	1	1
18-25 women	1	1	1	1
Middle Age				
25-60 Men	1	1	1	1
25-60 Women	1	1	1	1
Old				
60+ Men	1	1	1	1
60+ Women	1	1	1	1

The questions for the in-depth interviews were different from those of the focus groups for both women and men. The interview questions focused more on the villagers' actual experiences of the healthcare system, their satisfaction with the healthcare they receive and their healthcare utilisation behaviour (see Appendix 5).

#### **4.4.2 Questionnaire**

The sample for the questionnaire during the first round of the fieldwork was selected according to the socio-economic status of respondents. This sample was based on responses to the WeD RANQ, administered in 2004 by fieldworkers from KCU. In the RANQ villagers were asked to describe their household's economic status relative to other households in their community. The seven responses of RANQ can be categorised as:

- 1) The richest in the community
- 2) Amongst the richest in the community
- 3) Richer than most household in the community
- 4) About average in the community
- 5) A little poorer than most household in the community
- 6) Amongst the poorest in the community and
- 7) The poorest in the community.

While the precision of these categories was necessary for the accuracy of the WeD research, the researcher's research suggests that villagers normally refer to three simple

levels of economic status in the village, namely poor, middle and rich. For this reason the researcher used the survey categories to devise a simpler wealth ranking categorisation using three economic levels. Households were selected according to their economic wealth rankings, which were grouped as: the poor, the middle and the rich. The rich group comprised survey response categories 1-3, the medium group comprised categories 4-5 and the poor group comprised categories 6-7. The households were then selected according to their economic wealth ranking, using simple random sampling techniques, taking 30 percent from each wealth rank.

To ensure the samples were not biased towards one gender, the 216 questionnaire surveys undertaken were administered to an equal number of women and men in each village in this research. Questionnaires were used to interview one man and one woman aged 18 and above in each household. In *Baan* non-remote, 94 questionnaires were collected from 157 households. In *Baan* remote, 122 questionnaires were completed from 198 households.

#### **4.4.3 Validity and Reliability of Data**

Recognising the different understandings of validity and reliability within different fields of social science (for example, anthropology and health services research), the researcher opted to increase the veracity of findings by adopting a mixed and multi-method approach. According to Kirk and Miller (1986), the natural sciences tend to favour objective measurement which they see as more reliable, qualitative researchers acknowledge that reliability is important but tend to emphasise validity not in terms of statistical justification but on judgements about the richness and credibility of the data collected.

The approach to validity taken by this study is drawn from anthropological and interpretive methodologies, although it recognises the value of mixing methods from both qualitative and quantitative approaches (Kanbur 2001). According to the social anthropologist Clifford Geertz (1973), people see things through their own lenses, which means that they may appear to interpret the same phenomenon differently. For this reason one of the most useful and valid methods in the study of culture is deep involvement, typically through participant observation. This is supported by Kirk and Miller (1986:36) who write



‘We have no other technology for making this kind of validity check than long-run personal interaction. We can never be absolutely sure that we understand all the idiosyncratic cultural implication of anything, but the sensitive, intelligent fieldworker armed with a good theoretical origination and good rapport over a long period of time is the best check we can make’

In this study four main checks were applied to establish validity:

Firstly, the data was triangulated with secondary data from WeD which also explored what people have, what they do with what they have, and the meaning they attribute to what they have and do. WeD data was drawn from the Community Profiles, RANQ and the exploratory research for the development of the WeDQoL measure of goal satisfaction, as previously mentioned (see Chapter 4 page 139).

Secondly, a further triangulation was made of the researcher’s interpretations with the research assistants and the analyses of other researchers who had used the WeD data from Thailand (see for example, Guillen-Royo and Velazco (2006), Jongudomkarn and Camfield (2006), Jongudomkarn (2006), Camfield *et al.* (2007) and Camfield (2009).

Thirdly, the research applied a multi-method approach which collected data through questionnaire surveys, focus groups, in-depth interviews and participation observation. This is another form of triangulation which increases validity by combining different methods and asking different types of people to cross check the answers obtained (Samuttkub 2005). For example, the researcher interviewed four health workers who were working at the healthcare centre in the research area and two policy makers, who have been already mentioned (see table 4.1). She also used secondary data collected in the site, for example, administrative records, to supplement her primary data collection.

In attempting to build an accurate picture of the context within which people interpret their experiences of healthcare and wellbeing, it was necessary to also collect data at multiple levels, for example, community, household and individual. At community level, participant observation and focus groups were used to understand livelihood strategies and resources profiles, and gain an overall picture of the community. At household level, questionnaires were administered. At the individual level semi-

structured in-depth-interviews were used to obtain key insights on issues of well being in relation to the UC scheme.

Lastly, participant observation was undertaken, which included living with and talking with villagers in both communities. This technique is suitable for an in-depth exploration of villagers' perspectives, while allowing the researcher and participants to become more relaxed and friendly as interviews are conducted in the participants' surroundings. For example, Bryman (2001:289) describes how 'ethnography and participant observation entail the extended involvement of the researcher in the social life of those he or she studies' From this, the researcher managed to gain a clearer picture of the villagers' lives, including whether or not their wellbeing had improved over time, especially during the period of the UC scheme. These observations, often informal, helped the process of triangulation.

#### ***4.4.4 Ethical and Cultural issues***

Before starting data collection, the researcher spent a lot of time thinking about how to start and the best way to proceed. During the researcher's fieldwork some villagers asked questions such as 'we know that you will at some point finish your research but we wonder what will happen to us after this?'(Researcher field note 2005) To answer such questions, the researcher had to explain very clearly to villagers the nature and objectives of this research. This is related to the issue of research ethics.

Debates about ethical research arose in social science research in the 1960s and are still ongoing, thus it is not easy to resolve ethical dilemmas and problems that arise when carrying out research (Bryman, 2001). De Laine (2000) pointed out that ethical issues in fieldwork have been considered by anthropologists and sociologists. The purpose of developing and adhering to ethical guidelines is to create 'less harmful possibilities for making sense of people's life' (ibid :1). A general rule, which researchers should bear in mind, suggested by De Laine (2000), is that research should 'do no harm to participants'. Other principles that influenced the researcher's research included informed consent and anonymity.

#### **4.4.4.1 Informed consent**

In order to help villagers understand the purpose of the research, and to ensure participation, the researcher took time to explain the ideas and goals of the research (for example see the first page of the questionnaires in the Appendix 2). Most importantly this must be explained in the local language that all villagers can understand.

#### **4.4.4.2 Anonymity and confidentiality**

The researcher informed participants that their real names would not be used and they were guaranteed anonymity. The real names of both villages, for example, were changed so that respondents could remain anonymous. The following names have been given to the two communities studied: '*Baan non-remote*' for the non-remote village and '*Baan remote*' for the remote village.

In addition to primary data, the researcher made use of secondary data sources from local healthcare centres. This helped the researcher better understand how villagers use healthcare services. In order to access this information, the researcher sent out formal letters to the health care centres that provide health care services to villagers holding UC cards. The letter introduced the research project and asked for information on the medical records of villagers using the UC cards from 2002 to 2004. In addition, the researcher made contact with healthcare workers in order to explain the aims of the research personally, and to assure them that all information they provided would be kept confidential. The researcher also informed them that their names and the name of the centres would be anonymized.

Therefore, when presenting data from interviews, the anonymous identities for the healthcare settings and hospitals were applied. On some occasions, when having an informal conversation with villagers, the researcher did not ask people's age out of respect and to keep the conversation as natural as possible. In these cases, the researcher specified ages by categorising them as a young, middle-aged, or old man /woman.

#### 4.4.4.3 The local ethical issue: '*Kreng Jai*'

The ethical considerations discussed previously were very useful and helped the researcher get off to a smooth start. However during the fieldwork the researcher came across a more important issue that needed to be dealt with very carefully. The researcher found that even when participants agreed to participate in the research, they had reservations about the use of audio equipment to record interviews. This issue became more complicated when villagers allowed the recording of interviews out of politeness. This is the Thai custom of '*Kreng Jai*' whereby people may not be happy with a particular decision (such as the recording of interviews) but do not wish to protest for fearing of causing offence (in this case to the researcher).

The word '*Kreng Jai*' is a difficult concept to translate into English as there is no direct equivalent. However it can be translated as 'to be afraid of offending (one), to be considerate of another's feeling' (So Sethabutra, Thai-English Dictionary). Pornpitakpan (2000) cited in Chaidaroon, (2004: 8) explains the concept in the following way:

'[*Kreng Jai*] encompasses many elements: diffidence; deference; consideration; sensitivity toward others; reluctance to impose on or interrupt others; reluctance to assert one's comments, wants, or disagreements, especially to one's superiors; reluctance to negotiate with or give instructions to superiors; complying with other's explicit or implicit wishes or requests, especially if those come from superiors; concealing negative feelings, such as anxiety, resentment, and anger, to avoid making others uncomfortable or lose face; and reluctance to demand one's own rights (a non-smoker will patiently inhale the cigarette smoke from nearby smoker; a customer usually does not demand compensation for faulty products ).'

Given that '*Kreng Jai*' is an indirect form of communication it can be difficult to recognise. Therefore it is easy for some to misinterpret such behaviour, especially those from other cultures. For example, Philips (1965) cited in Naemiratch (2006) called this social interaction an exercise of 'social cosmetic'. Barr (2004) offers a useful illustration. He explains the case of a man who worked in Thailand for three years and

gradually learnt to understand that the discrepancies between what people said and thought were not the product of dishonesty. Rather it reflected a Thai value system, which is based on harmony and a desire not to hurt another's feelings. In order to avoid conflict and maintain social harmony especially in face-to-face situations the dynamic of '*Kreng Jai*' comes into play.

In addition, this value is instilled into Thai citizens early on and is seen in the following saying '*Khwarm Kreng Jai pen Som Bat Khong Pu dee*', which means '*Khwarm Kreng Jai* is a treasure which belongs to good mannered people'. Thais are therefore expected to behave in a way consistent with '*Khwarm Kreng Jai*' and failure to do so may result in people being labelled insensitive.

In the case of the researcher's research, '*Kreng Jai*' occurred when people agreed to participate in the research but had reservations about being recorded. However instead of making such feelings known they would talk so softly and quietly that the equipment was unable to record their responses. This made the task of transcribing very difficult. Given that the researcher had previous experience of researching these communities, the researcher was left with the impression that '*Kreng Jai*' is more common now than when the researcher carried out research for an MA thesis ten years ago.

There may be three reasons for this influence/ bias. First, ten years ago the researcher was a young student and now (2004-2005) the researcher had become a senior university lecturer and moreover, a mature PhD student studying overseas. This seniority and privileged position affected the relationship between the researcher and the research participants. Second, ten years ago the researcher was not aware of the importance of '*Kreng Jai*', and therefore believed that what participants told the researcher was what they really meant. Perhaps this reflected the researcher's research naivety. Finally, for the researcher's MA thesis, audio equipment was not used and so it is likely that the issue did not even arise.

The lessons learnt from this experience made the researcher realise that in order to understand the 'under surface' phenomena in Thai society, some of the more conventional or universal ethical principles may not be sufficient. On the other hand, to learn and understand local ethical issues such as '*Kreng Jai*', might be useful for others who are also trying to understand Thai society when doing research.

The point the researcher would like to emphasise here is that researchers should go further than a 'do no harm' approach but also take preventative and precautionary measures to respect interviewees' culture. From the researcher's experience, it is very important to create good relationships between the researcher and villagers; this is known as a '*rapport building*' process. When villagers became familiar with the researcher they seemed more open minded. This enabled both the researcher and the villagers to be relaxed, and the researcher to be better able to deal with the issue of '*Kreng Jai*'. The '*rapport building*' process is important in order to understand the villagers' context, but this process is limited when using an opinion poll survey.

In some cases, researchers such as Helliwell (2007) believe that the result derived from their evaluation tool (e.g. a Gallop World Poll) has generated a much boarder view of life satisfaction than other measures. In Helliwell (2007)'s view

'The case I am making is that when people evaluate their life satisfaction they mean what they say, and their answers are meaningfully comparable across communities, nations and cultures, and through time (2007: 16).

Although the researcher agrees with Helliwell (2007) that we cannot ignore what people say, in some cases people may not mean what they say. This is particularly true in Thai culture where positive responses are common especially when the researcher has not build a good rapport with the people. Therefore using only the poll may not be enough to contribute to our understanding people's life and their wellbeing. Moreover, doing research should involve consideration of the process of interaction between researchers and interviewees, rather than purely the product (data) (Samutkub, 2005).

The method of using an audio recorder did not work well during the fieldwork. A better way to interview villagers was to talk to them in a more natural context. Keeping a diary of field notes, writing what happened every day was very useful. This strategy opens up the question of recall and memory. Is it possible to remember all the details observed in a day? Thus, a multi method approach when undertaking research may help the researcher to cross check the data and better understand the wellbeing of villagers. In addition, the multi method approach could be flexible regarding the situation of the research context.

#### **4.4.4.4 Lesson learnt from interviewing ‘women’s issues’**

In order to investigate female experiences of cervical cancer tests, the researcher found that it was necessary to adopt gender sensitive interviewing skills.

The issue of gender sensitivities arose in the field when the researcher was acting as a translator for the WeD health project in the south of Thailand. This helped the researcher understand that better quality in-depth interviews could be achieved if the rapport between interviewer and interviewee is strong and full of trust. In one interview with a woman suffering a long-term illness, she informed the researcher that her body had physically changed after she had given birth to her children. When the researcher (as a translator) asked her to explain what kind of body changes had occurred, she covered her face with both hands and did not reply. Her body language meant that she did not want to answer the question. This reaction could be due to certain factors. First of all, we were not familiar with each other as it was the first time we had met. Second, there was a man present during the interview so the interviewee was even more embarrassed by the questions.

This experience led the researcher to think about how to improve the method of asking about cervical cancer issues in the researcher’s own fieldwork. Statistically, cervical cancer is ranked as the primary cause of death among Thai women (Phommo 2005). When collecting data in 2005, the researcher saw campaigns at healthcare centres, hospitals and through other forms of mass media, aimed at raising awareness of cervical cancer and encouraging female villagers to take precautionary measures.

Figure 4.1 Poster promoting cervical scans at a healthcare centre.



Translation of Thai words: All women should have cervical scans regularly.  
Source: The researcher's own picture

In fact, when interviewing women, the researcher realised that she was also being interviewed by them. Being an outsider to the community, educated and a single woman, made the researcher an object of interest for female villagers. Women were keen to hear about the researcher's age, marital status, the researcher's time in England, the researcher's own cervical cancer test results, and so on. At times, these conversations lasted for hours but the researcher found them a very useful means of creating good relationships with the women. It seemed to partly even out the interviewer-interviewee relationship, because as a result of the informal conversations, women were happier to take part in the research.

During one interview, a young women told the researcher that she had never talked of 'women's issues' with anyone else in her entire life. No one had ever asked or told her



about such issues and she did not know how to find relevant information. It seems that in Thai society this kind of conversation causes embarrassment. This issue is important and will be discussed in Chapter 7, page 282-283. Taking these issues into consideration, the researcher then interviewed each of the female participants about cervical cancer and the testing for it, individually in their own homes. The interviews about cervical cancer occurred after the researcher and female villagers had known each other for some time. The researcher had also told them that they could stop at anytime if they did not feel comfortable with the content of the interview. It was important not to end up in a situation of '*Kreng Jai*'. In the researcher's view, interviewing women about a sensitive issue need not be a problem if there is a strong enough relationship between the researcher and participant. Moreover, such an interview can be a wonderful moment when views and experiences as women can be shared.

## **4.5 Data analysis**

The data analysis in this study is organised according to the two types of approaches the study used i.e. qualitative and quantitative. Furthermore, the analytical process was divided into two: 'in the field' and the 'after the field' analysis. The preliminary analysis, which took place in the field, was partly completed whilst the researcher was still in the village. All data, both the questionnaires and the interviews, were checked for errors. Each day after the questionnaires were collected, the researcher read them and checked for errors, for example, to see if the assistants had forgotten to ask certain questions record some important answers. If the researcher discovered mistakes then the assistants were asked to correct them wherever possible. Otherwise, the assistants would go back to the respondents for clarification. These checks discovered some mistakes that could be solved especially in the case of the questionnaires. After the 'cleaning process', data from the questionnaires was then entered into SPSS by the researcher and a research assistant, so that errors in data entry could be avoided. Any problems were fixed through meetings and discussions with the research assistant. The data entry finished in late March 2005.

The qualitative data was mostly collected in audio format. Audio recording allowed the researcher to gain important details, although transcribing was time-consuming. After the data was recorded from each interview, the researcher initially tried to transcribe

whilst in the field, which helped the researcher check the accuracy of the data. However, the amount of work was immense, which led most of the transcriptions to be done after the researcher returned to Bath in 2006. In addition to audio recording, field notes and diary field notes were used for collecting data. The most important point in using a field note diary is that the data must be written down soon after the observation or conversation has finished in order to preserve the data context. As mentioned earlier, in many cases informal conversations provided the most useful insights. Most data from field notes and field note diaries were preliminarily analysed in the field in order to check the adequacy of the data. Data transcribed from audio recordings and from field notes and field note diaries were then typed into a word document in both Thai and *Isaan* languages in order to keep the true meaning from the interviews.

The ‘after the field’ analysis of the questionnaire was done through a descriptive analysis of frequencies. The data was analysed using cross tabulation to examine the differences in uptake and use of the UC card among villagers from different groups, i.e. gender, economic class and age. In addition, T-test and one-way Analysis of Variance (ANOVA) were used to examine differences in satisfaction in the use of the UC card among these villagers from different groups. The T-test was used to analyse the differences in satisfaction when using the card between women and men. The one-way Analysis of Variance (ANOVA) was used for testing the levels of satisfaction with the card among villagers from different classes and age groups.

The ‘after the field’ process of the qualitative analysis began with data coding. Initially, the coding of the qualitative data was conducted by using the computer-assisted qualitative data analysis software (CAQDAS) called NVIVO<sup>33</sup>. According to Bryman (2001) the emergence of CAQDAS is one of the most significant developments in qualitative research. Although using NVIVO helped the researcher to easily identify and locate particular respondents, it was found that encoding Thai data using NVIVO was a complex process. This was because during the time of data encoding, the programme was not able to support Thai fonts<sup>34</sup>. In addition, there was the issue of using two different languages, English and Thai. Most of the interview data was collected in Thailand and transcribed into Thai and *Isaan* language. If the researcher decided to use

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<sup>33</sup> The significant of using software to analyse qualitative data is also well explained in Richards and Richards (1994).

<sup>34</sup> The version that the researcher has was an old version. The new version of NVIVO which supports Thai language is now available.

NVIVO, all of the 24 in-depth interviews and the 6 focus group discussions would have needed to be translated into English. This could have resulted in the alteration of original meanings of the data, and therefore leading to wrong interpretations. Moreover, as a PhD student, the researcher had limited time and budget and thus spending a lot of time on translation was considered impractical. As a result, the analysis was completed by coding the data manually. The data was coded in Thai according to the research questions. Only the responses that are quoted in this thesis were translated into English.

The majority of interview data was coded by the researcher in order to sharpen the researcher's understanding of the data and to ease the process of analysing the data. The data was coded based on research questions of the thesis which included:

- Who has the UC card and who does not and why?
- The reason/s for using and not using and why?
- How satisfied the villagers are with the UC scheme and how this links with satisfaction with life?

The coded data was also linked in order to highlight relationships between the responses. Comparisons across cases were carried out to identify the main similarities and differences. Finally, the findings were explored to investigate their relationship to existing literature, and to consider whether they established new theories or concepts or raised issues that had been overlooked in research into healthcare and the wellbeing of villagers in northeast Thailand.

## **4.6 Conclusion**

This chapter has discussed the research methodology and its justification, in particular its role in attempting to develop a holistic approach to evaluating the UC scheme. This involved considering the researcher's fieldwork experiences and highlighting some important ethical issues in the research sites. According to Kanbur (2001), Gough and MaGregor (2007) and the researcher's own experience, using a multi-methods approach, which is a combination of quantitative and qualitative methods, has allowed the researcher to understand how the UC scheme has contributed to the villagers' wellbeing. In addition, it has helped to crosscheck the results generated from the

different researchers and different research methods. For example, while a large-scale survey is helpful in outlining the characteristics of the non-remote and remote villages, participatory observation allows the researcher to understand the reasons behind their characteristics, having provided more ‘thick description’ as suggested in the work of Geertz (1973). The researcher found that flexibly structured and open interviews allowed access to information that would have been difficult to pick up using quantitative techniques. Keeping the structure flexible facilitates dialogue and flow of the conversation. This is crucial in order to probe people’s experiences of life in depth and, in particular, their experiences of wellbeing as a result of the UC scheme in relation to their background, identities, culture and beliefs. A multi-methods approach has therefore facilitated a more holistic understanding of the wellbeing of the villagers. This leads into the discussion in the next chapter, where the research site context is explained, and the effect of this socio-cultural background on the access to healthcare in the two locations is explored.

## Chapter 5: Putting the research sites in context

This chapter explains the context of the research sites and includes an introduction to the communities', households', individuals' and villagers' situations, in relation to their access to the UC scheme. There are five sections in this chapter. The first provides brief details about the Northeast of Thailand, where the research sites are located. The second outlines details of the two communities selected for the research. The third section describes the socio-economic backgrounds of the villagers in the study. The fourth section describes the health infrastructure at each site and the role of factors such as location, socio-economic status, and culture in influencing villagers' access to these facilities. The final section concludes.

### Box 5.1 Thailand Background

The Kingdom of Thailand is located in central Southeast Asia. It is bound by the Andaman Sea to the west, Myanmar (Burma) to the west and northwest, Laos to the east and northeast, Cambodia to the east and Malaysia and the Gulf of Thailand to the south. There are four major regions in Thailand: North, Northeast, Central and South.

Thailand was also known as 'Siam', but its name was changed after colonialism and means the 'Land of the Free' [from colonialism]. With 76 provinces, its size is 198,456 square miles, roughly the size of France, and its population in 2002 was approximately 63.2 million. There are slightly more females than males (31,744,700 females, 31,516,500 males) and the sex ratio males: a female is 99.28:100.

Thailand is a multi-ethnic and multi-religious society. However, the majority of its population is Thai; they speak Thai and are predominantly (95 %) Theravada Buddhist. Part of the population is made up of people of Chinese origin who are followers of Buddhism, Taoism or Confucianism and there is a significant minority in the south of Thailand who are Muslims. In addition, there are various indigenous tribal peoples, who still practise traditional faiths.

Sources: Summarised from World Bank, 2003

Figure 5.1 Map of Thailand



Source: [http://www.travelfish.org/country\\_map/thailand](http://www.travelfish.org/country_map/thailand)

## 5.1 The historical background of Northeast of Thailand or *Isaan*

Figure 5.1 shows the map of Thailand and the location of the northeast region, where the two research sites are located, one in Khon Kaen and one in Mukdahan. The Northeast is the largest region in terms of its geographical area and population and is located on the Khorat Plateau. It is known as '*Isaan*' in Thai and is commonly known as the poorest region in terms of its lack of natural resources as well as its economic and political marginalisation<sup>35</sup>. As discussed in Chapter 2, *Isaan* people in general have suffered from higher poverty levels compared with the other regions (NESDB 1999 cited in Phongpaichit and Baker 2000). Recently, a report by the World Bank found that although the reduction of poverty has been making progress in Thailand, in the northeastern region it still remains high: almost 90 percent of the poor live in rural areas and of these rural poor, more than 50% live in the northeastern provinces (World Bank, 2006).

According to Ekachai (1990), *Isaan* has always been drier and less fertile than other regions of Thailand. Drought is a regular feature of this area and has constantly pushed substantial numbers of villagers into a cycle of debt and migration. The natural resources are of low quality: saline soil, sandy soil, water shortages, poor irrigation systems, and the highest levels of deforestation, which have made the land less productive compared to other parts of the country. This low quality of natural resources, in particular water shortages, is the key factor contributing to the highest incidence of poverty in this area. Because most farms are still dependent on rainfall, the sustainability of water resources in this area has been one of the key targets of the National Plan (National Economic and Social Development Board-NESDB, 1992).

In terms of land usage, agriculture remains dominant in the region. However, as most of the area available for cultivation is on sandy soil and affected by large variations in rainfall, the crop yields and productivity rank amongst the lowest in the country. Consequently, the northeast is the poorest region in terms of per capita income and this leads many villagers nowadays to seek alternative jobs, such as factory work, labouring,

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<sup>35</sup> The history of political subordination of *Isaan* is profoundly discussed in the work of Mattariganon (2000).

construction or taxi driving, mostly in Bangkok. As pointed out by Rigg (1997), approximately half of all migrants in Bangkok are from the *Isaan* region.

In order to understand how the region has reached its present day situation, it is essential to understand its unique history. In the 13<sup>th</sup> century, *Isaan* was one of the Angkor Empires and then performed the role of a buffer zone between Thailand and Laos from the mid 14<sup>th</sup> century. Throughout the long period of the Thai-Laos war, a number of people from Laos migrated to Northeast of Thailand or *Isaan*, which was eventually taken over by Siam in the 19<sup>th</sup> century (Wyatt 1963).

In 1897 King Rama the fifth (Chulalongkorn) announced administrative reform to unite the nation of *Siam* during the period of European colonialism in Southeast Asia. Ever since the establishment of village local administration<sup>36</sup> *Isaan* villagers have had a village head, who is a formal representative from central government. However, even though the government has been highly influential in the *Isaan* region, and the identity of the *Isaan* people has been shaped by Bangkok's hegemonic control, they still follow the cultural traditions of Laos rather than those of central Thailand or the 'True-Thai'<sup>37</sup> (Keyes 2005). Most of the *Isaan* people are commonly known by the rest of the Thais as *Khon Lao* or Lao people.

It is apparent that the cultural divide between the Thai people and the *Isaan* people is wide as they are different in historical background, language and cultural heritage. This differentiation has led this region to be thought of as a 'minority'. People from the mainstream culture see themselves as superior to the *Isaan* people [considering them as 'Siew'<sup>38</sup>] especially those who are not fluent in Thai and behave differently. Therefore,

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<sup>36</sup> This Act was developed later by King Rama the sixth in 1914 and has continued until the present (Department of Provincial Administration 2009).

<sup>37</sup> The True-Thai idea relates to Thai national history when the concept of 'Thai-ness' was introduced in the 19<sup>th</sup> century. Most people living in the Chao Phaya river basin who speak only Thai dialects are considered to be 'True-Thai', whereas other regions that are more diverse, such as the Northeast where the 'Thai-Lao' live, have been classified as belonging to a regional or 'ethno-regional' identity, rather than incorporated into the national ethnic identity (Keyes 2005).

<sup>38</sup> A discriminatory word used to call *Isaan* people in order to make them feel embarrassed and insulted. This indicates that Thai people had extremely limited knowledge of *Isaan* culture, as the word 'Siew' in *Isaan* means close friend. The tradition of *Isaan* people called 'Phook Siew' or a ceremony for friends to become close friends is still practised in many parts of the region.



in this context, *Isaan* can be referred as an ‘Ethnos’<sup>39</sup> community as defined by Delenty as

‘minority communities with a high proportion of migrants or their decedents, and other communities which identify themselves on the basis of ethnicity, religion or language’ (Delenty 1998 cited in Philips and Berman 2003:344).

After World War II in 1945, Thailand entered a period of rapid development. There were several processes of economic development, democratisation and modern ideologies that emerged in Thai society. However, it was the authoritarian government of General Sarit that launched a period of rapid growth in the late 1950s. The development strategy, which included the eradication of poverty in poor areas, especially those of the rural northeast, was chiefly aimed at the prevention of communist infiltration. Over recent decades there have been marked rises in average income, even in the relatively deprived areas such as the northeast (Morrell and Chai Anan, 1981).

Despite significant improvement, the Northeast region still remains disadvantaged compared with other parts of Thailand, in terms of people’s quality of life. One quality-of-life (QoL) study by Ayuwat and Phaitakham (2004) found that, indeed, *Isaan* people have a lower level of QoL than people in other regions. Their study showed that every province in Northeast Thailand failed two of the Basic Needs Indicators (BNI)<sup>40</sup>, from 1992 until 2001. One of these indicators is whether children aged 6-12 are vaccinated against five major diseases. The other is whether citizens with the right to vote, do in fact vote.

In addition, the results of the Human Achievement Index (HAI)<sup>41</sup> have demonstrated that the region’s scores on health are the lowest in the country (UNDP 2003). The

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<sup>39</sup> ‘Ethnos’ and ‘Demos’ are associated. While ‘Ethnos’ refers to individuals and communities, ‘Demos’ is a macro level such as nation state and society (Berman and Philips 2000).

<sup>40</sup> Basic Needs Indicators or Basic Minimum Needs Indicators (in Thai *Jor Por Tor*) is a tool for measuring the quality of life of Thai people. In 2002-2006, the Thai BNI was composed of 37 indicators. BNI indicators were divided into six main groups: 1) Good health; 2) Adequate housing; 3) Education; 4) Progress in income; 5) Teaching of Thai values; and 6) Participation in the development process.

<sup>41</sup> The HAI has been developed by the UNDP. There are eight elements: 1) Health; 2) Education; 3) Employment; 4) Income 5) Housing and Living Conditions; 6) Family and Community Life; 7) Transportation and Communication; and 8) Participation.

health component is possibly the most significant indicator of quality of life in Thai society. This is shown by the fact it has often been used as the prominent tool in the BNI, the HAI and even by the powerful National Economic and Social Development Board-NESDB<sup>42</sup> in Thailand.

With regards to the health service, the number of health workers is still inadequate. The highest ratios of health workers per total population are in Bangkok and other provinces in the central areas, whilst the area with the lowest proportion of health workers to total population is the Northeast. In 1979, the doctor to population ratio in Bangkok was (1: 1,210), whereas in the Northeast region it was (1: 25,713). However, the disparity between Bangkok and the Northeast region has recently improved. In 2002 the same ratio in Bangkok was (1: 767) and in the Northeast region it had been reduced to (1:7,251). Although the gap has decreased, inequality remains: Bangkok still has ten times as many doctors per total population as the Northeast region (MOPH, 2004). Moreover, the government's *per capita* health expenditure in the Northeast region is the lowest compared with that of other regions (The World Bank, 2006); this offers further evidence for the Northeast region's relative deprivation.

It can be seen that *Isaan* has not only been suffering from unequal shares of the nation's development resources but also this reflects various deprivations in this region which have not yet been fully tackled by the government. This can be explained by the following reasons. First, the national development goal during the rapid development period was focused on economic growth and industrialisation rather than the agricultural sector, the main source of income of the region (Phongpaichit and Baker 2000). Second is the historical conflict between the central government and the region, as shown by a number of movements and organisations, has been formed throughout the years to represent the *Isaan* people's demands. One of the major assertions of their political voice was the Peasant's Federation in 1974 (*Sahapan Chao Na Chao Rai*) which was later dismantled by the violent suppression policy under the communist demolition policy. This led many people to feel discriminated against by the government. Recently, in the 1990s the Assembly of the Poor (*Samatcha Khon Jon*) was formed which was considered as one of the most striking political movements of the

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<sup>42</sup> The health indicator was ranked by the NESDB in 1997 as the highest ranked indicator of seven indicators of the Thai people's wellbeing (see Chapter 3 page 116)

rural villagers in Thailand since the suppression of the Peasant's Federation in 1979, according to Baker (Baker, 2000).

In order to understand the development process and the issue of marginalisation in the Northeast of Thailand in relation to the UC scheme, it is necessary to consider the historical context and socio-cultural background of the region. This thesis therefore attempts to explain the situation in the region, in particular when the Thai Rak Thai (TRT) party approaches the communities using populist policies, by applying the concept of social quality of Phillips and Berman (2003) and Berman and Phillips (2000). According to Phillips and Berman (2003), the concept of social quality is proposed to analyse and understand the wellbeing of the society rather than the individual. Social quality offers a broader level than quality of life due to its focus on groups, communities and societies rather than on individuals. Phillips and Berman (2003) classify social quality elements into two dimensions: internal aspects of community social quality and external aspects of community social quality. The internal aspects relate to the potential of communities themselves and are composed of: socioeconomic security, social cohesion, social inclusion and empowerment. The external aspects relate to 'the nature of societal social cohesion and the extent to which the community itself is socially included in society' (ibid: 348).

The policies of the TRT party offer a sense of socioeconomic security to the poor and many *Isaan* people are attracted to the policies because they recognised that they are included in the social and economic system. Because of the TRT pro-poor policies, poor people in the northeast felt that they are better served by the TRT government and treated equally to other Thai citizens. This explains why villagers felt gratitude to the party and would have previously supported the TRT government. Therefore it is not surprising that this region was one of the major supporters of the (TRT) and its populist policy<sup>43</sup>, particularly the UC scheme that has been one of its centre pieces. The popularity of the party and its policies among the *Isaan* people has been shown by the TRT winning a majority of seats in this region in every general election. For example, in 2001 they won 102 out of 136 seats. In 2005 the number was 126 out of 136 and in

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<sup>43</sup> In fact before the TRT party, this region was a main supporter of the ruling 'New Hope' party which offered a mega project called 'Green *Isaan*' to the region during 1989-1993, lead by ex-PM Chaovalit. However, after the 1997 economic crisis this party collapsed and many representatives moved to the TRT party. The New Hope party was known to be allied to the TRT party.

the latest election in 2007, the People's Power Party (PPP), the TRT party's precursor, won 104 out of the 141 seats available (Thai Parliament, 2008). Nevertheless, it is important to note that the quality-of-life study has marked the *Isaan* region as the area that has continuously failed in each of the last ten years to achieve the BNI's 'citizen, with the right to vote' target. The question is: what has led to people in this area getting actively involved in elections and what has driven them to become supporters of the Thai Rak Thai party?

## 5.2 The two research sites in context

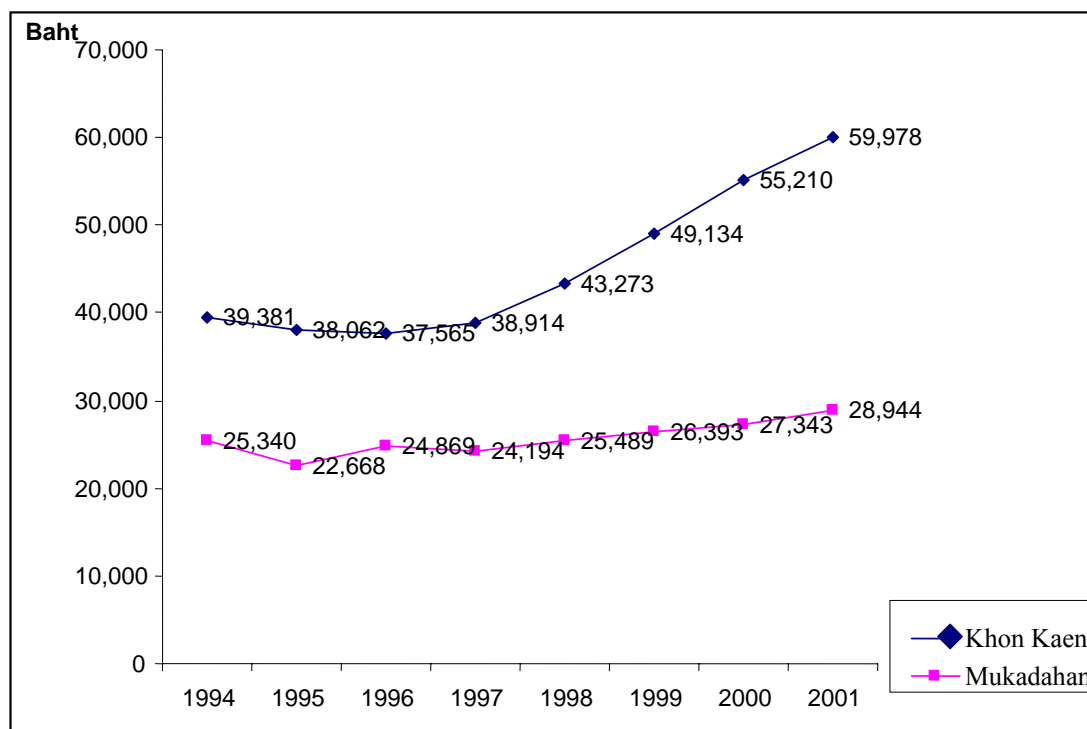
Two research sites were selected for this thesis: a non-remote village in Khon Kaen province and a remote village in Mukdahan province. Comparing the two provinces, Khon Kaen has a slightly better economic situation in terms of income per capita than Mukdahan. In 2000, the incidence of poverty in Mukdahan was still high compared with Khon Kaen, 24.2 % to 17.2%, respectively, whereas the national average stood at 14.2% (UNDP, 2003). According to the UNDP 2003 report, the average monthly household income in 2000 was 9,485 Baht (approximately 158 pounds) in Khon Kaen, and 9,114 Baht (approximately 152 pounds) in Mukdahan. Recently, Khon Kaen has been rapidly developing and according to the National Economic and Social Development Board (NESDB) it grew the fastest of the eleven upper-*Isaan* provinces.<sup>44</sup> The NESDB calculated the Gross Provincial Product (GPP)-per capita<sup>45</sup> between 1994 and 2001, and found that Mukdahan has experienced steady growth, but at a lower rate than Khon Kaen.

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<sup>44</sup> The upper *Isaan* consists of eleven provinces. These are Lei, Mukdahan, Nakornpranom, Mahasarakham, Nongbualampoo, Khon Kaen, Nong Khai, Sakonnakorn, Udontanee, Roiet and Kalasin.

<sup>45</sup> Total value of goods and services produced in the province each year divided by the population. In general, the smaller the number, the less economically developed the province is.

Chart 5.1 Gross Provincial Product (Per Capita) of Khon Kaen and Mukdahan



Source: Adapted from the data of NESDB, 2004

The rapid development of Khon Kaen is not simply down to financial gains, but also due to improved education and healthcare facilities. There are many educational institutes and the leading state university, Khon Kaen University, is one such example. In addition, there are private universities, technical colleges and numerous high schools as well as five well-established hospitals in Khon Kaen City (NESDB, 2004).

In terms of health facilities, the number of health workers per population total in Khon Kaen is higher than in Mukdahan. For example, in 2003 there was one doctor per 2,928 people in Khon Kaen, whereas in Mukdahan this figure was one per 8,139 people. In fact, the doctor to population ratio in Khon Kaen for 2003 was even higher than that of Bangkok (1:3,433) (UNDP, 2003).

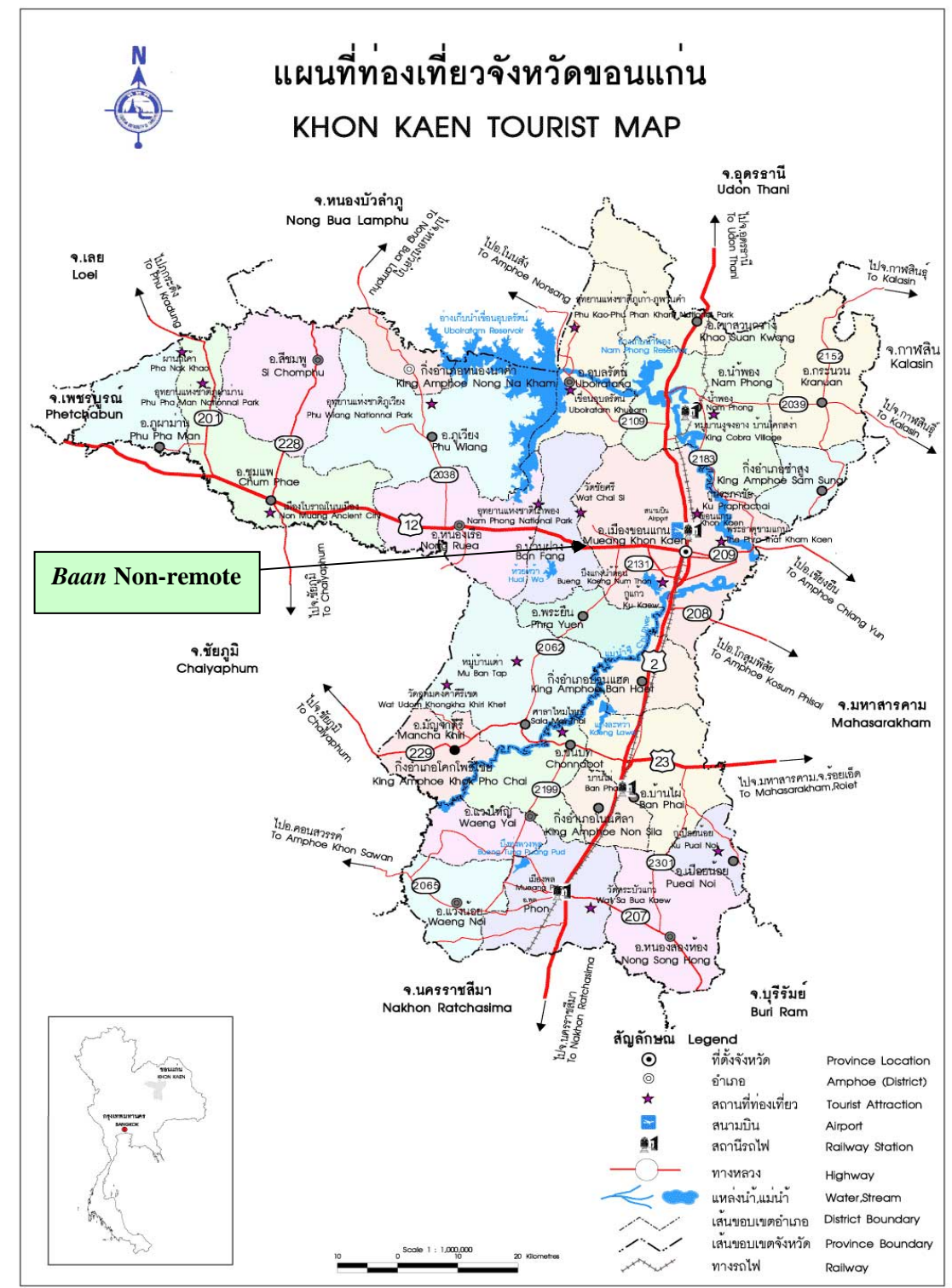
It can be seen from the above that although both provinces are located in the same region they have important differences. The next section introduces the two research sites in detail.

## **5.2.1 Introducing *Baan non-remote***

### **5.2.1.1 Geography**

*Baan non-remote* is located about 17 kilometres away from Khon Kaen city centre. Figure 5.2 shows the map of Khon Kaen and its geography, highlighting the Maliwan Road (no. 12) which the villagers use for travelling to the city. The highway no. 2 is the Mitaphap or ‘Highway of Friendship between Thailand and America’ after World War II, connecting Bangkok with Laos.

Figure 5.2 Map of Khon Kaen Province



Source: <http://www.tourismthailand.org/map/khonkaen-40-1.html>



It is not difficult for villagers to go to Khon Kaen if they do not have their own vehicle, the modes of available transport ranging from a motorbike taxi, which villagers called ‘Skylab’(figure 5.3), to taking a minibus (figure 5.4). These vehicles enable the villagers to reach the city centre within 15-20 minutes.

Figure 5.3 and 5.4 Transport for non-remote villagers



Source: The researcher’s own picture

The village is surrounded mostly by fields and there is a plentiful supply of water, both natural and artificial, the former from the villagers’ own ponds and the latter from government-built wells. This water is used for both agricultural purposes and domestic consumption by the villagers (WeD Community Profile, 2005).

Figure 5.5 and 5.6: Examples of houses in *Baan* non-remote.



Source: The researcher’s own picture



The differences between the houses is obvious, with the house on the left being an example of a poor house. It can be seen that this has a poorer quality structure and the two children living here are receiving funding from Christian Children's Fund (CCF). The house on the right is an example of a modern house and the owner is regarded as the rich. These variations were also spread throughout the village.

### **5.2.1.2 Infrastructure and key events in the village**

The village has developed moderately rapidly which can be summarised as the following timeline.

- 1803 The first migratory group of people
- 1870 The first village leader
- 1939 School established
- 1973 Rice mill established
- 1975 The villagers started to work at the fishing net factory
- 1976 The construction of an asphalt street
  - The first shop opens in village
  - The renovation of well and pond for water supply
- 1979 The first underground water
- 1980 Electricity connected
- 1981 A well for the cattle built
- 1986 Poor students started to receive funds CCF
- 1987 Temple established
- 1992 Villagers started selling their land to the capitalists
- 1993 Contact started with the farmer foundation and a women's weaving group established
- 1995 Pond renovated for water supply
- 1995-6 Water supply provided with a rate of three Baht per Unit
- 1996 Home telephones connected
- 1997 The asphalt street was turned into concrete street
- 1999 Governmental project for poverty alleviation established (*Krong Gan Kae Panha Khwarm Yakjon -GorKorKorjor* project)
- 2000 The Social Investment Fund (SIF) provided funds for poor people
- 2001-2 The introduction of the UC scheme

Source: Adapted from the WeD community Profile (2005)

Remark: 1997 to 2000 Period of Economic Crisis in Thailand

The above timeline illustrates the development of the village in terms of infrastructure. Since the 1970s, problems with drought and water supply were a significant factor for poverty alleviation as villagers were mainly in agricultural sector. This led to difficulties for their productivity and income. In response to the shortage of water supply, many villagers had to switch to raising cattle and working at the fishing net factory as growing rice requires a lot of water. The government had to provide the underground water for villagers and two years later a well was built for the cattle. Additionally, poor children and their families started receiving aids from an NGO, the CCF, which has continued its activities in the village to date. However, the other main infrastructures such as water supply, telephone and good roads were only established in the mid 1990s. In fact, there is one public telephone but it is unworkable so many people use mobile phones for communication. In 2005, 58.9 % of households owned a mobile phone (RANQ 2005). This data shows that governmental infrastructure investment in this village was still inadequate as discussed earlier.

An increase in governmental projects and poverty alleviation policies can be seen in the late 1990s from the introduction of the 1999 *GorKorKorjor* project, followed by the 2000 SIF project which offered Thailand a loan by the World Bank. In fact, in order to respond to the 1997 economic crisis, Mr Chaun's government at that time established the community's stability and strengthening policies. Two examples of this are the poverty alleviation policies such as *GorKorKorjor* and SIF project. These policies attempt to strengthen communities as they are considered as a fundamental unit of the country. The researcher, as an academic, still remembers how many new projects were introduced to the villagers at that time by government, non-government (NGOs) and academics. The media referred to this phenomenon as 'rural fever'.

### **5.2.1.3 Socio-economic characteristic**

The population

According to the WeD community profile, in 2005, there were 177 houses containing 935 people: 475 male and 460 female. The average population is approximately 5 persons per house. The major ethnic group living in this village is Laotian, or *Thai-Lao*, or *Thai-Issan*.

## Occupation

The main occupation of the villagers was in the agricultural sector. However, there was an increasing number of industrial and construction workers as well as labourers at the time of the survey (RANQ, 2005 and the researcher's questionnaire surveys 2004). A great number of people, in particular women, were working in the fishing net factories. Whilst female teenagers were working in the factories and being covered by social security schemes (SSS), most of the middle aged women with families were restricted to working at home as 'informal sector labourers' for factories, without SSS healthcare coverage.

According to Elson and Pearson (1998) the labour market is structured by gender and age. Most factory managers seek young women to work for them as they can make more profit from the enterprise. This is because female labourers are considered 'cheaper' and have 'higher productivity' compared with men (Ibid, 1998:192). The 'nimble fingers' of women, according to Elson and Pearson (1998), make them particularly suitable for tasks involving dexterity and patience, such as making fishing nets.

Home workers added two different components to fishing nets that they collected from the factory, one being floats and the other lead weights<sup>46</sup>. The pay is 9 Baht per piece for the former and 6 Baht for the latter (about 15 pence and 10 pence respectively). Completion of one task, such as attaching a float, generally takes about 3 hours and working all day might produce up to three pieces with remuneration of about 27 Baht, equivalent to about 45 pence a day (Researcher's field note, 2004).

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<sup>46</sup> Many women said that they had a blood test in order to assess their bodily lead levels about eight months to a year prior to interview. This test was organised by a group of medical students from KKU and the women were relieved to hear that their lead levels had not gone up, owing to the precautions they were taking, like washing their hands, etc.

Figure 5.7 A woman working at her home, whilst being interviewed by researchers.



Source: The researcher's own picture

Some older women were aware of their low wages and some of them had approached the factory owners to complain about the situation. Nevertheless, their pleas were ignored by the owners and they were told, 'you are old and cannot work in the factory so this is the best choice for you' (Researcher's field note, 2004). In addition, most women did not know how to protect their rights as workers or how to assert themselves so as to be able to confront problems in the workplace.

Most middle aged men work outside their homes, in the fields, raising cattle, and, away from their village, driving mini buses, motorcycle-taxis and working in construction in Khon Kaen City. Most villagers also reported that many male teenagers are unemployed and spend their time 'hanging around drinking alcohol'. After finishing seasonal work in the rice fields, many middle-aged villagers, both men and women, migrate to work as sugarcane cutters in the central part of Thailand in and around Kanchanaburi and Ratchaburi Provinces. These people who left the villages for work were unable to vote in the general election in 2005 and there were about 200 voters absent from this village at that time (Researcher's field note, 2004 and 2005). It is important to note that these 200 villagers would also have been unable to access the UC in case of illness or injury,

as they would not have transferred their registration. This issue will be further discussed in Chapter 6.

### Village Politics

According to WeD community profile (2005), Baan non remote had the first village leader in 1870. However, the political relationship with the central government was established in 1900 when the second village leader who came into position.

In terms of the role of the village leader, according to the 1897 Local Administration Act, the key duty of the village headperson is to look after the wellbeing of the villagers from birth to death. For example, one of the duties of the village leader is 'registration of the population and constantly update it' (Department of Provincial Administration 2009). Another important role is to assist the government to maintain the security of the village. In summary the village leader plays a significant role in the villagers' life.

As village leader represent the lowest level of the administrative structure of the central government authority, they also have to power to control their villagers in order to sustain harmony in the village. The next levels of the administrative structure are: the Tambon Administrative Organisation (TAO), district, province and central government.

Since the village head has a close connection with the local and national politicians, therefore this important role of the village leader is used by the politicians as a way to gain votes from villagers. The relationship between the village leader and politicians is well-known as a 'patronage system'. The notion of a patronage system has appeared in many articles, theses and books in Thai academia (see for example the work of Phognsapich, 1996).

Although the researcher is still considered by villagers as an outsider and so politics in the village are not easy to understand within a short period of time during the fieldwork, two main observations may explain the nature of politics in this village.

First, many villagers expressed that they are not satisfied with the 30 Baht scheme. One main reason is that it offers low quality. However another reason, from informal

conservation, is that many villagers were still supporters of and informally worked with politicians from different parties (Researcher's field note 2005).

Another group showed that they supported the 30 Baht scheme as is the case with the following example:

‘Many university students don’t like Thaksin. They think Thaksin did a lot of corrupt things. But for us, Thaksin helped us, we are poor so we need the government to help us’ (A middle aged women, focus group discussion 8 December 2004)

This division between the villagers is interesting as it is apparently in line with the wider trend of the country’s situation, where people are either for or against the TRT and its policies.

## Religion

Similar to most Thai people in the country, villagers are Buddhist. There are two temples: one is inside the village call *Wat Baan* (Home temple) and another on the outskirts call *Wat Pa* (Forest temple). Both temples are used for regular merit making (see below). However, the home temple is also used for the purpose of village meetings and the forest temple is used for cremations.

Figure 5.8: The temple in *Baan non remote*.



Source: The researcher's own picture

Buddhism plays a vital role in villagers' lives. Most villagers were taught to practise good *kamma*<sup>48</sup> in order to gain their wellbeing. The notion of *kamma* is one of the fundamental teachings of the Buddha which relates fortunes in the present life to deeds from a previous life. In the same way, to improve one's next life, *kamma* can be accrued in the present. In summary, when everybody practises good *kamma* they will pursue their own wellbeing individually, which in turn means increasing the wellbeing of the society.

For villagers, merit-making is seen as one way of improving *kamma* in the present. The merit-making involves various activities such as offering food to the monks every morning, practising the five precepts<sup>49</sup>, having sons enter monkhood, donating money and giving service to the temple. Some villagers believed that good *kamma* bring good health, wealth and fortune and this will be discussed in Chapters 6 and 7.

## **5.2.2 Introducing Baan remote**

### **5.2.2.1 Geography**

*Baan remote* is found in the Mukdahan province. Figure 5.4 shows Dong Laung district in which the village is located. Mukdahan city is situated close to the Thai-Lao border. Highway no 212 is used to travel from Mukdahan to Nakhon Phanom province connecting with highway no 9 of Laos. Road no 2287 is used to travel to Mukdahan city, which is approximately 80 kilometres from the village. Travelling to the Dong Luang district, approximately 40 kilometres from village, involves a long journey and may take around an hour on the bus pictured on page 183.

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<sup>48</sup> See for example Ajahn Sucitto (2008) for a detailed explanation of *kamma*. Ajahn Sucitto explains that 'the principles of *kamma* link 'external' behaviour to the 'internal' practice of meditation. And that meditation is one kind of *kamma*-the *kamma* that leads to the end of *kamma*. In fact '*kamma* and the end of *kamma*' is a useful summary of what the Buddha had to offer as a path to well-being and Awakening' (2008: i).

<sup>49</sup> 1. Refraining from killing any kind of creatures. 2. Refraining from stealing anything that is not given. 3. Refraining from sexual misconduct. 4. Refraining from false speech and 5. Refraining from the use of intoxicants



Source: <http://www.tourismthailand.org/map/mukdahan-49-1.html>

This village is surrounded by a national park forest with two small streams close by the village. The forest and streams are sources of natural food, fuel and herbs, which are used in local medicine for the village inhabitants. Due to their abundance, the villagers can use these resources throughout the year and this village has never experienced a shortage of water, unlike the experience of the non- remote one.

The climate here is quite cool in comparison to other regions in Thailand. The main road to the district town runs through the village and the village is divided in two. But in terms of areas the village is comprised of the three main areas, which will be named as ‘big’, ‘small’ and ‘water’.



Figure 5.10 The transport for remote villages, which runs twice a day, morning and afternoon



Source: The researcher's own picture

Figure 5.11 and 5.12 Examples of houses in *Baan* remote



Source: The researcher's own picture

The two houses above are not that different from the houses in Baan non remote. Both are built in the traditional style with the underneath used for keeping animals such as chickens or cattle.

### 5.2.2.2 Infrastructure and key events in the village

Around 1794	A highly respect monk from Sakonakorn province led the first group of people to settle in the ‘big’ and ‘small’ areas; some people are from Lao
1945	Expansion of the villagers to the ‘water area’
1971	The Primary School was established.
1973-1980	Most villagers moved to be allied with the communist movements and live in the Forest of <i>Phu Phan</i> Mountain
1979	The first village leader started in office
1979	The first rice mill was set up.
1980	The first dirt road was built by the government
1981	A water supply system was provided, supported by the government
1982	The dirt road was turned into asphalt; also an artesian well was built by the government
1983	Cassava was introduced into the village by the government
1986	Electricity was connected and a nursery was started.
1989	The nursery building was constructed by the government.
1999	Telephone services were introduced into the village.
2001-2001	The introduction of the UC scheme
2005	Rubber trees were introduced to the villagers

Source: Adapted from the WeD community Profile (2005)

The timeline of *Baan* remote shows again late investment in governmental infrastructures in the village. The increasing government attention to this village can be seen in the introduction of the village leader, rice mill and dirt road at the end of 1970s and early 1980s. These developments are due to the government policy of reducing communism in this area and explain why this village received main infrastructure improvements from the government at almost the same time as the non-remote village, with the public telephone arriving even before the non-remote one. However, this sole public telephone in the village was usually out of order. In case villagers needed to communicate with the outside world, there was one private home telephone, which they had to pay to use. The cost varied, depending on the distance of the call, from about 10-20 Baht per minute. Mobile phones could not be used owing to the lack of network coverage (Researcher’s field note 2005). This situation with regards to contact with the

outside world caused many difficulties to the villagers, particularly in the case of emergencies.

The introduction of the road in 1980 has had a major impact on the villagers' lives. This is because has opened up connections with state and local markets which in term means it is easier for outside people to contact villagers. While some villagers see the advantage of this connection, some see more problems. On positive side for example, the villagers can access school and a primary health care centre and hospital more easily in recent years. In addition, villagers are able to sell their products at the local market and merchants from nearby provinces can come to buy their products. Drawbacks of better connection to the rest of the world from villagers' points of view are also reported, for example villagers have contracted new diseases that had never happened before, such as diabetes. Some villagers expressed their belief in the focus group discussion that the diabetes came from food from the market in particular from the Monosodium Glutamate (MSG) (Researcher's field note 2005).

In 2005, the government introduced rubber tree plantations all over the northeast of Thailand, including the remote villages. The desire to participate in this policy has encouraged many villagers to increase their need for the documents to their land. This is because the policy will support only villagers who have legal documentation of their land, but the fundamental problem is the lack of rights they experience as the village area is a part of a protected national park (WeD Community Profile 2005).

### **5.2.2.3 Socio-economic characteristic**

The population

There were 196 houses with a total of 786 people in the village in 2004. The average population was similar to the non-remote figure which is approximately 5 persons per household. However, in terms of ethnicity, the villagers are not the '*Thai-Lao*' group as found in the non-remote location. They were from a variety of backgrounds, such as the: '*Yor*', '*So*', '*Broo* or *Ka*', '*Phuthai*' and '*Thai-Lao*' ethnic groups (WeD-Community profile 2005).

According to Keyes (2005), there are many smaller ethnic groups in the Northeast of Thailand; these are generally undistinguished and viewed as belonging to the '*Thai-Lao*' group by most people. In one interview, a healthcare worker noted that a language barrier affected villagers' access to healthcare, because they came from different ethnic groups (Researcher's field note, 2004).

### Occupation

Agriculture is the main occupation of villagers in this area and most are dependent on just a few crops, such as cassava and rice. The community profile (WeD 2005) reported that a large proportion of the villagers in this village were producing cassava (150 from 198 households), whilst the rest were growing rice. Recently, the price of cassava has fallen and the government has encouraged villagers to grow rubber trees as mentioned earlier. However, land rights have posed a main problem for the villagers, as most of the village land is part of the national park. Although they have been settled here for 200 years, they still have to pay land tax of 1 Baht per rai<sup>50</sup> and they continue to struggle for these rights, as they have done for decades. In addition, having no right over their land also means they cannot use their land to guarantee their rights when needing to borrow money from a bank or other organisations (Researcher's field note 2005).

Apart from working in their own farms, many villagers work as agricultural labourers on others' land, both in their own village and in neighbouring villages. They are paid between 100 Baht and 150 Baht per day for doing this work (about £1.6 and £2.5, respectively). Cultivating food and collecting free forest products are the other villagers' occupations. There are plenty of free foods from the so-called 'fresh supermarket', which can be collected every season of the year, such as ants' eggs, honey, green vegetables, bamboo shoots, wild mushrooms and wild animals. These foods are consumed by the families or they are sold in the villages or to merchants from nearby towns.

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<sup>50</sup> A *rai* is a Thai area unit equal to 1600 square metres (40 m × 40 m) and there are 2.5 *rais* per acre.  
<http://www.nationmaster.com/encyclopedia>

Figure 5.13 An example of villagers' food from their fresh supermarket.



Source: The researcher's own picture

In order to collect these foods the villagers have to wake up before dawn and walk through the hills for many hours. They believe that this activity contributes to their good health and consider it as their 'exercise', so when healthcare workers promoted 'aerobic dance' among the villagers, they did not show any interest. Moreover, in the focus group discussion many claimed that the dancing embarrassed them. As one woman put it: 'I feel so embarrassed to dance and jump in front of my children. I can't do it. They [the children] will laugh at me (giggle)' (Focus group 19 February 2005). It can be seen from this aerobic dancing does not work well in those villages where the villagers hold more 'traditional' values.

A number of villagers have migrated to Bangkok and other urban areas such as Pra Nakorn Sri Ayutthaya, to look for off-farm income for their families. Many of the temporary migrants are female teenagers who are still studying in school, but work in the school holidays. While female villagers usually work in factories, the males are taxi drivers, in construction or workers in furniture factories. The most common reason given by villagers for going to work in Bangkok, in particular amongst the young, was to: 'gain experience just like their friends' (Researcher field note, 2005). Some villagers

migrate permanently and only return for the *Songkran* or Thai New Year in April. Most migrant workers send money back home to support their families (RANQ, 2005 and the researcher's questionnaire surveys 2005).

### Village Politics

The political relationships of *Baan* remote relate to its history with the central government as shown in the timeline of the village. Between 1973 and 1980, most villagers abandoned their homes and fled to the forest to escape the government authorities. Many villagers, especially the middle aged and elderly, told stories about this time. One morning, whilst having breakfast, a villager expressed how other villagers were treated unfairly by the government. He said 'the government killed many innocents because villagers were accused of being communists' (A middle aged man, Researcher's field note 2005).

The folk song below is a good example of how the villagers felt about the Thai government when they were forced to abandon their homes and live in the forest between 1973 and 1980 (Researcher's field note 2005).

An *Isaan* folk song

Oh ha oh ha oh ha O

Oh ha oh ha oh ha O

*Isaan* is now in trouble.

Because of our superiors.

They are strict on suppression.

Agriculturists are subdued.

Agriculturists are charged to be communists.

Innocents are imprisoned.

The hated are killed.

Is it reasonable?

People cannot make any comments.

They used power to oppress.

They, gangsters, shoot people.

The superiors do not have morals.

They are villains who betray the country.

Oh ha oh ha oh ha O

Source: Sung by Phi Sun, 12 February 2005

In the past, villagers had the experience of the government condemning them as communists, because fairness and equality were and still are highly valued in this village. The idea of 'equity' is evidently reflected in the results of the questionnaire: most villagers believed that the UC card should be equally implemented for all Thais (see chart 7.3 in Chapter 7).

When considering the political relationships and social structure in this village, it was found that the village was dominated by one large family. This is because the village leader has been a member of this family since the village has its official leader in 1979. In addition, the first village leader from 1979 has now become a subdistrict leader which is another level of the [administrative or] Tambon Administrative Organisation (TAO). Moreover, this leader also owns his cassava business in the village and most of the villagers often carry their produce to sell to him (Community profile 2005 and Researcher's field note 2005)

Due to the leader's powerful stance, it is not easy to criticise him or the inside village politics as he has huge support from his extended family and many villagers. In addition, with their prior experience of being condemned as communists, villagers seemed to be very careful when talking about politics. Thus most data about village politics came from informal conversation which expressed more opinion about politics outside the village. For example, while collecting data in 2005, Thailand was preparing for the national election. The researcher asked which party the villagers were planning to vote for. Surprisingly the answer was not the TRT which is the ruling party at that time and won the seat in this area in the 2001 election. The main reason for their voting intention was that since the 2001 election the representative had never come back to help the villagers in this area, moreover the representative was very 'stingy'. Villagers referred to one occasion of the village's merit-making where this representative refused to send money to help the merit-making. Finally, the TRT did not get a seat from villagers in this area in 2005 (Researcher's field note 2005)

Another event observed by the researcher when doing focus group interviews is that while most villagers tended to be satisfied with the UC scheme, most health volunteers complained about the UC scheme in terms of its low quality and bad management. This includes comments about some politicians in the government. A villager claimed that



one of the Thaksin government members used to work with villagers while he took refuge in the forest when struggling against the government, but he seems to have forgotten this relationship and has never come back to help the villagers.

## Religion

People of *Baan* remote, together with the rest of the region, were predominantly Buddhist. From the research observation it has been found that villagers are religious, which has been expressed in different ways. For example, merit-making taking place on a daily basis and every morning the villagers start the day with Buddhist activities.

Figure 5. 14 A Buddhist monk walks through the village, in the early morning.



Source: The researcher's own picture

In addition, there are three temples and one shrine which is a temporary temple, or in Thai, *Sam Nak Song*, which the villagers go to in order to gain good *kamma*, merit-making and to participate in religious observance such as listening to the teaching of the Buddha given by the monks in the village.



Figure 5.15 and 5.16 Examples of the temples in *Baan remote*.



Source: The researcher's own picture

Figure 5.17 and 5.18 Examples of the merit-making activities in *Baan remote*.



Source: The researcher's own picture

The two temples at the top of the page are places where villages can go to perform merit-making. The two pictures at the bottom are where people performed their merit-making. Merit-making is also a chance for villagers to participate in the community's festival and usually ends with sharing food together afterwards.

Further, the village has many historical records regarding Buddha and people claimed that this village was a centre for Buddhism in the past, arising from the belief that there is a footprint in the temple thought to belong to Buddha. There is further speculation by

the villagers that this area which they considered is a part of Vientiane; the capital of Lao, will become very well known with the expected birth of the next Lord Buddha in this village (Researcher's field note 2005). The villagers expressed more of an affinity with Laos than Thailand and felt they were ethnically closer to Lao than Thai. They explained that they were still waiting for the 'millennium' when Vientiane will be prosperous again. This idea of the 'millennium' is thought to be linked to the historical background and the communist movement in the village which was strong during the late 1970s and early 1980s.

An example of teaching received by villagers from a Buddhist is illustrated below:

'Many people need a lot of material in order to live. But the real goal of life is in fact to find a peaceful mind. This is the core of our living. One can work well, gain a lot of money but if one has not known the word 'enough' or does not know how to moderate it, the unsatisfied mind can take hold and one will lose the way to reach the real goal of life. In order to live well one needs to keep balancing both the material and the mind' (A middle- aged monk 18 November 2005).

This teaching reflects the importance of religion in both the way of life and the value of life of villagers in this area. Satisfaction occurs when villagers know how to balance their desires. As discussed in Chapter 3, this value on moderation or 'enough' is considered as one fundamental factor of satisfaction amongst Thai people.

### **5.3 Villagers' profile comparison from field survey**

This section presents the profile of respondents in the two villages using data from the survey questionnaires. The total number of respondents was 216, of which 47 were men and 47 were women in *Baan* non-remote and 61 men and 61 women in *Baan* remote (see Table 4.1 in Chapter 4). Table 5.1 shows the demographic and socio-economic profile of the villagers in both locations.

Table 5.1 Demographic and socio-economic profile of the sample

Characteristics	<i>Baan non-remote</i>		<i>Baan remote</i>	
	N (94)	%	N(122)	%
<b>Gender</b>				
1. Men	47	50	61	50
2. Women	47	50	61	50
<b>Age</b>				
1. 18-25	2	2.1	19	15.6
2. 26-60	70	74.5	95	77.9
3. >61	22	23.4	8	6.6
<b>Marital Status</b>				
1. Single	7	7.4	12	9.8
2. Married/living together	75	79.8	103	84.4
3. Widowed	7	7.4	6	4.9
4. Divorced	0	0	1	0.8
5. Other	5	5.3	0	0
<b>Education level</b>				
1. No schooling	0	0	43	35.2
2. Primary school	82	87.2	59	48.4
3. Early secondary school or equivalent	4	4.3	17	13.9
4. Early vocational certificate/higher secondary school	5	5.3	2	1.6
5. Bachelor degree	2	2.1	0	0
6. Other	1	1.1	2	0.8

Table 5.1 Demographic and socio-economic profile of the sample (continued)

Characteristics	<i>Baan non-remote</i>		<i>Baan remote</i>	
	N (94)	%	N (122)	%
<b>Income/ year (in Baht)</b>				
1. $\leq 20,000$	12	12.8	14	11.5
2. 20,001-40,000	22	23.4	30	24.6
3. 40,001-60,000	12	12.8	40	32.8
4. 60,001-80,000	12	12.8	20	16.4
5. 80,001-100,000	8	8.5	10	8.2
6. $>100,000$	28	29.8	8	6.6
Min	8,000		8,000.0	
Max	310,600		331,000.0	
Mean	79,981.9		55,814.8	
<b>Expenditure/ year (in Baht)</b>				
1. $\leq 20,000$	6	6.4	8	6.6
2. 20,001-40,000	16	17.0	58	47.5
3. 40,001-60,000	24	25.5	26	21.3
4. 60,001-80,000	28	29.8	10	8.2
5. 80,001-100,000	4	4.3	12	9.8
6. $>100,000$	16	17.0	8	6.6
Min	10,294		2,400.0	
Max	162,796		402,480	
Mean	63,990.2		49,232.3	
<b>Saving/year (in Baht)</b>				
1.No saving	78	82.9	92	75.4
2. $\leq 20,000$	11	11.7	20	16.4
3. 20,001-40,000	2	2.1	10	8.2
4. 40,001-60,000	1	1.1	0	0
5. 60,001-80,000	1	1.1	0	0
6. 80,001-100,000	1	1.1	0	0
7. $>100,000$	1	1.1	0	0
Min	0		0	
Max	400,000		40,000	
Mean	7,290.4		3,726.9	
<b>Debt/ year (in Baht)</b>				
1.No debt	37	39.4	15	12.3
2. $\leq 20,000$	24	25.5	52	42.6
3. 20,001-40,000	14	14.9	23	18.9
4. 40,001-60,000	2	2.1	11	9.0
5. 60,001-80,000	4	4.3	4	3.3
6. 80,001-100,000	4	4.3	2	1.6
7. $>100,000$	9	9.6	5	4.1
Min	0		0	
Max	1,030,000		385,000	
Mean	52,401.8		34,334.3	

Source: Researcher's questionnaire surveys 2005

For every household one woman and one man were interviewed and, as explained in Chapter 4, where there was no married couple other adults were surveyed. As shown in Table 5.1, 47 couple were interviewed in *Baan* non-remote and 61 in *Baan* remote. Most of the villagers in *Baan* non-remote (74.5%) and *Baan* remote (77.9%) were in the middle-aged group (26-60 years old). The reason why there was a lower number in the younger group in *Baan* non-remote compared with *Baan* remote is that the younger people in *Baan* non-remote had a greater tendency to travel to the city for school and work, for example the fishing net factory, as described in section above. In both villages most of those interviewed were married (79.8 % in *Baan* non-remote vs. 84.4% in *Baan* remote). The majority of villagers in *Baan* non-remote (87.2%) had completed primary school, compared to less than half in *Baan* remote (48.8%). In summary, this study found that the two villages have a similar socio- demographic structure except for educational level. The reason for this difference in educational level is that many older villagers (35.2%) in *Baan* remote did not enrol in school because this village was involved in the communist movement in the 1970s and many of the older villagers took refuge in the forest, as explained earlier. Only two people in either village who had completed higher education and neither of them lived in *Baan* remote. This finding is not unexpected, because monetary poverty was a fundamental problem for villagers. This, coupled with the long distances to upper secondary and higher educational institutions involving high transport costs, prohibited them from being able to attend.

Most villagers in both villages had an income of more than 20,000 Baht a year<sup>51</sup>, with the average annual household income of *Baan* non-remote and *Baan* remote being approximately 80,000 and 56,000 Baht, respectively. It can be seen that whilst the biggest group of respondents in *Baan* non-remote (29.8 %) had an income of more than 100,000 Baht a year, the biggest group of respondents in *Baan* remote (32.8 %) earned between 40,001 Baht to 60,000 Baht a year, and very few villagers (6.6 %) in *Baan* remote earned more than 100,000 Baht a year.

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<sup>51</sup> According to the national poverty levels, people who earn less than 20,000 baht a year are considered poor (NESDB 2006). This research thus employs the number as a base in dividing income, expenditure, saving and debt among respondents.

With respect to aggregate income and expenditure<sup>52</sup> of the two villages, respondents reported that the main sources of income of the respondents in *Baan* non-remote were: wages<sup>53</sup> (2,108,000 Baht per year) followed by salary<sup>54</sup> (1,832,400 Baht per year) and borrowing (1,261,000 Baht a year), whilst in *Baan* remote selling produce was the most common source (2,788,000 Baht a year) followed by borrowing (2,239,600 Baht a year) and then salary (648,000 Baht a year). This data shows that villagers from *Baan* non-remote and *Baan* remote have different sources of income, reflecting a greater range of off-farm occupations in the non-remote village. However, in the remote village there is more income ‘in-kind’ than in the non remote location. The income in kind refers to the gathering of natural products from the nearby forest, as mentioned earlier in the village description (see also figure 5.13). That is, the main sources of income in *Baan* remote are more agriculturally based than in *Baan* non-remote.

The average annual household expenditure of *Baan* non-remote and *Baan* remote was approximately 64,000 and 50,000 Baht, respectively. The largest group of villagers in *Baan* non-remote (29.8%) spent more than 60,000 Baht a year, whereas in *Baan* remote the largest group (47.5%) of villagers spent substantially less, that is between 20,001 and 40,000 Baht per year. The greatest expense all for the respondents in *Baan* non-remote was on food (2,680,008 Baht per year) followed by payments for agricultural activities (917,378 Baht a year) and transportation (563,760 Baht a year). In *Baan* remote the respondents’ largest expenditure was on food (1,926,960 Baht a year) followed by agricultural payments (1,096,154 Baht a year) and credit payments (1,094,376 Baht a year).

In terms of health expenditure, it was found that in *Baan* non-remote 92.6% of villagers paid for healthcare, compared to only 31.14% in *Baan* remote. Villagers in *Baan* non-remote spent twice as much on health care compared with *Baan* remote (143,061 Baht and 73,560 Baht, respectively). However, when comparing the villages’ expenses, in particular with regards to travel and accommodation costs, it was found that people in the remote village spent five times as much on these, on average, as those in the non-remote location (43,920 Baht and 9,401 Baht, respectively).

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<sup>52</sup> All income and expenditure figures presented here are the total income and expenditure of the respondents from the two villages.

<sup>53</sup> Irregular sources of income, such as from labouring, or working in a factory

<sup>54</sup> A regular monthly salary

In both villages most villagers had had no savings in the previous year (82.9 % in *Baan* non-remote vs. 75.4% in *Baan* remote). 39.4 % of villagers in *Baan* non-remote had no debt, whilst 42.6 % of villagers in *Baan* remote had debts of less than 20,000 Baht. It was found that the amount of debt in both villages was much higher than the levels of savings. Many villagers attributed this to the cost of inputs and payments for agricultural activities. *Baan* non-remote had debts totalling 4,925,770 Baht, an average of 52,401.8 Baht/per household, whilst total savings were 685,300 Baht, an average of 7,290.4 Baht/per household. By contrast, *Baan* remote had total debts of 4,188,780 Baht, an average of 34,334.3 Baht/per household and 454,680 Baht total savings, averaging 49,232.3 Baht/per household. It can be seen that debt was about 9 times greater than savings in *Baan* remote and 7 times greater in *Baan* non-remote.

Figure 5.19 This is an example of how villagers become in debt.



Translation of Thai words: 'Loan, starting at 0.50 satang' (0.50 satang is half of one Baht. 1 Baht is composed of 100 satang and 60 Baht is approximately 1 pound sterling).

Source: The researcher's own picture

## **5.4 Access to healthcare**

Various factors affecting the villagers' access to healthcare will be discussed in this section. These include geographic, socio-demographic, economic and cultural as well as lifestyle-related factors. It is crucial to bear in mind that these are not separate influences on healthcare access as there are a number of circumstances in which they are closely related. This section presents an overview of the findings with detailed discussion in Chapters 6 and 7.

### **5.4.1 Geographic**

Villagers from both sites have access to healthcare; that is each villager is registered for one primary health centre and one hospital according to their place of residence.

Regarding the non-remote village, the hospital available to them is a private one which has joined the UC scheme.

Although on paper both villages have equal access to healthcare, the non-remote one has the advantage of being closer to the healthcare facilities. For example, whereas the journey time, by motorbike, to the primary health centre from the non-remote site is 5 minutes (3 kilometres), in the case of the remote village it is around half an hour (15 kilometres). In addition, whilst non-remote villagers could reach the hospital within 10 minutes (it also had a free ambulance service), the remote villagers had to take a day off work to get to the hospital, owing to the lack of public transport. For them there were only two public buses to the hospital per day, taking approximately 45 to 60 minutes. Even by private transport the journey was still time-consuming and took at least 30 minutes. In addition, to get to hospital the remote villagers spent five times more than the non-remote in travel costs as mentioned earlier. Moreover, the non-remote villagers also had access to a number of clinics in Khon Kaen City, including a university hospital called Srinagarind Hospital, which is known as one of the leading hospitals in *Isaan* (NESDB, 2004). The hospital attracts patients from other provinces in the Northeast and amongst these patients are people from the remote village, provided they can afford to pay. There is a second major government hospital, Khon Kaen Central, and also a growing number of private hospitals. In addition, the Queen Sirikit Heart



Disease Centre provides ‘super-tertiary’ care<sup>55</sup>. All of these large specialist hospitals are for fee paying patients only, except those people who have a referral from their local hospital. Khon Kaen also has the main branch of the NHSO, where people from across the northeast region can get further information regarding the UC scheme entitlement. Obviously, it is easier for the non-remote villagers close to Khon Kaen to take advantage of this service than the remote villagers (Researcher’s field note 2004). The NHSO building is illustrated in figure 5.20.

Figure 5.20 The NHSO branch in Khon Kaen Province



Source: The researcher’s own picture

The fact that the non-remote villagers were able to access multiple healthcare facilities is reflected in the results from the RANQ (2005). Among the villagers in *Baan* non-remote, 70.7 % of the household heads perceived that they had adequate healthcare services, whereas only 50.5% of the remote villagers felt that that was the case.

In terms of other infrastructure, such as the standard of the roads, those in the non-remote village fare better, and as a consequence transport in this area is easier than

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<sup>55</sup> There are normally three levels of healthcare provision: primary, secondary and tertiary. However, the Queen Sirikit Heart Disease Centre provides a ‘super-tertiary’ level as it is meant to be the centre for treatment of heart disease in the region

around the remote village. Although good roads make travelling to the city easier, especially for emergency patients, some villagers commented that one of the disadvantages of having good roads is the greater frequency of accidents, as they allow motorcycles and cars to go faster (Researcher's field note 2004).

It is found that during the group interviews (30 November 2004, 25 February 2005) with villagers in both villages, many complained that road accidents had recently increased. It was their understanding that they could not use the UC card in these cases, whilst in fact, according to interviews with policy makers and healthcare workers (14 December 2004, 15 February 2005), they can use the card. The proviso is that the patient must have traffic accident insurance, which is paid by all car and motorcycle users to private insurance firms. However, it was found that in most cases villagers did not have traffic accident insurance, although the insurance is a legal requirement for anyone driving a car or bike, which has led to many villagers misunderstanding the eligibility criteria.

In addition to being far away from the health facilities, the remote village is also bordered by forest thus malaria is still widespread. It is found that in 2003, 11 percent of the sample had malaria, which is a high proportion of the population (Researcher's questionnaire surveys 2005). A villager told a story of a student from Bangkok who came to the village to carry out a development project and returned with a fever which turned out to be a bad case of malaria. Owing to a misdiagnosis after he returned home he eventually died from the disease. This story led to this researcher investigating further the preventative measures employed by visiting a malaria clinic near the local healthcare centre. The malaria staff said that they offered 'Permanet'<sup>32</sup> for impregnating mosquito nets. However, although this preventative measure was available, most of the villagers did not use it, because of its strong smell and their belief that ordinary mosquito nets were effective enough (Researcher's field note 2004 ).

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<sup>56</sup> In order to prevent malaria transmission, 'Permanet': a long-lasting, insecticide-impregnated mosquito net was introduced on April 14th, 2003 by the WHO and it was passed by the WHOPES (WHO Pesticide Evaluation Scheme) in 2004 ([www.permanet.com](http://www.permanet.com))

Figure 5.21 A malaria clinic near to the village



Translation of Thai words: *Baan Pang Deng* malaria clinic, free diagnosis and treatment.

Source: The researcher's own picture

In addition, whenever remote villagers had emergency health problems and needed to go urgently to hospital, their relatives with transport would help them get the medical attention they needed. However, those who did not have these kinds of 'social resources' had to hire a private car from their neighbour, at a cost of 500 Baht each time – approximately five times the average daily wage of the villagers (the average wage is 100-150 Baht per day) (Researcher's field note 2004).

These results clearly indicate that even if in theory the UC was put in place to promote 'equal access to healthcare' for everybody, in reality the services are still mostly clustered in and around city locations. In other words, the remote village still has unequal access to healthcare services compared to the non-remote village, due to high transport costs, lengthy travel times, and fewer alternative choices,. As a result, the remote villagers sometimes have had to rely on their own resources, by utilising traditional methods of treatment.

## 5.4. 2 Socio-demographic

### *Sex and Gender*

Sex and gender, i.e. the biological and social dimensions of differences between men and women, are important influences on villagers' healthcare access. Women and men were found to have remarkably dissimilar health problems and divergent requirements due to both gender and sex. The most evident example is the finding that women in both villages sought medical advice principally in order to access services regarding family planning and birth control. This reflects both their physical capacity to bear children and the social norm that they bear sole responsibility for this. From the questionnaire, it was found that 100% of married female participants are responsible for family planning as indicated in Table 5.2 below.

Table 5.2 Users of family planning service by gender

Item	<i>Baan non-remote</i>		<i>Baan remote</i>	
	N (94)	%	N(122)	%
Have you accessed family planning service?				
1. Yes	64	68.1	88	72.1
2. No	30	31.9	34	27.9
Who uses family planning service?				
1. Male	0	0	0	0
2. Female	64	100	88	100

Source: Researcher's questionnaire survey 2005

As for men, it was discovered that the majority of the informants were reluctant to seek medical care. As described above, some of the differences in terms of healthcare access between men and women are related to gender rather than sex and this will be discussed further in the later section on culture and lifestyle.

In order to clarify the divergence regarding healthcare access between the two genders, the research also examined perspectives and attitudes of men and women in both villages. The results are presented in Table 5.3 below.

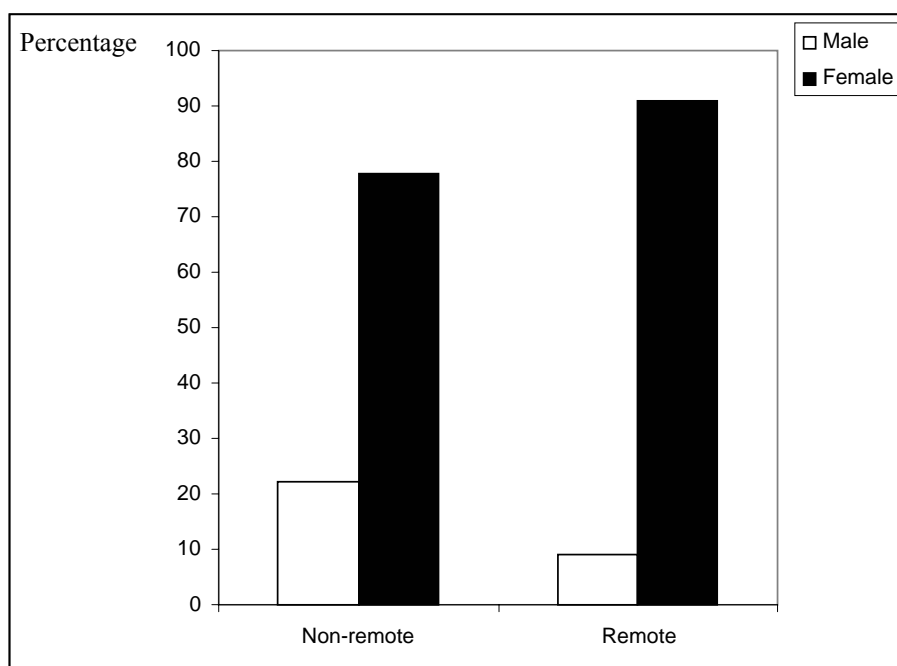
Table 5.3 Concepts of health and healthcare access by gender in the two villages

Item	<i>Baan</i> non-remote		<i>Baan</i> remote	
	N (94)	%	N(122)	%
In general, do men and women suffer from illness caused by the same disease?				
1. Similar	41	43.6	41	33.6
2. Different	53	56.4	81	64.4
Who, in general, gets sick more easily?				
1. Male	21	22.3	11	9.0
2. Female	31	33.0	70	57.4
3. Either	42	44.7	41	33.6
Who, in general, goes to see a doctor more often?				
1. Male	21	22.3	11	9.0
2. Female	73	77.7	111	91.0

Source: Researcher's questionnaire surveys 2005

Table 5.3 illustrates that most villagers in both sites believed that male and female illnesses were caused by different kinds of disease. While the villagers in *Baan* non-remote believed that both men and women had a similar chance of getting sick, more than half of villagers in *Baan* remote agreed that women became ill more easily than men. In addition, villagers in both sites believed that although women always take better care of themselves, in general they visit a doctor more often than men. The perspectives and attitudes of men and women in the two villages regarding healthcare access are more clearly illustrated in Chart 5.2.

Chart 5.2 The villagers' perceptions regarding the relative frequency of men and women's visits to doctors



Source: Researcher's questionnaire surveys 2005

Chart 5.2 shows that 77.7% of respondents in *Baan* non-remote and 91.0% of respondents in *Baan* remote agreed that women went to visit a doctor more frequently than men which could be potentially explained in three ways. Firstly, as mentioned earlier women not only see a doctor because of their illness, but they also need to utilise the family planning service. Another reason could be because women tend to be more health conscious than men. In addition, on many occasions, women also bring family members in particular children and the elderly to hospitals. These reasons are related to gender and culture in Thailand and will be discussed in greater detail in Chapter 7.

### Age

Table 5.1 (section 5.3) indicates that the majority of research participants are middle aged. Regarding age, it was found that as with gender villagers in both locations shared a common perception that people in different age groups have a tendency to experience dissimilar illnesses. Furthermore, age also influences the villagers' attitudes towards medical treatments, which affects their utilisation of healthcare service. The result of the

focus group revealed that the villagers in both locations held a similar view that children constituted the healthiest age group. This was due to the belief that children tend to be largely healthy and are usually looked after by their family. However, villagers in the two locations had dissimilar opinions on the group that they perceived to have the most health-related problems. The participants in the non-remote village perceived that people of working age or who were middle-aged suffered most from medical problems, given that they usually spent a considerable amount of time working and tended not to look after themselves properly.

For example, people in this age group might have gastric ulcers as they cannot always have regular meals due to their hard work. Moreover, the villagers believed that men tend to suffer more from gastric ulcers than women given their greater alcohol consumption. Participants in the remote village on the other hand, perceived that health is a greater problem among the elderly. The villagers suggested that as old people's bodies deteriorate, they usually suffer from knee and back pains which results in the habit of regularly taking painkillers.

However, according to the staff of the local medical center in the non-remote village, the majority of people who access healthcare service are those of working age and the elderly (Researcher field note 2005). Nevertheless, it was found that only a small number of old people in the remote location had sought medical care, although this group of villagers suffered the most from health-related problems. The phenomenon can be explained by several potential reasons. Firstly, given the distant location of the medical center and limited means of transport available (buses depart only twice a day), older people tend to have considerable difficulty traveling to visit doctors. The second reason which appears to be the main explanation is the fact that they continue to rely largely upon traditional methods of treatment in the form of herbal remedies and so do not use formal health services. An elderly female villager from the remote location revealed that she regularly take herbal drinks which helps to stimulate blood circulation thereby relieving aches and pains. These remedies which are easily obtainable and cost nothing are extremely popular among older people in the village.

### *Marital Status*

The majority of the research participants are married (see Table 5.1). Marital status was found to be one of the crucial factors that influenced the villagers' healthcare needs. For

example, women who have children in both villages are extensive users of healthcare services such as the aforementioned family planning and birth control.

In addition, it was discovered that the health-related problems of married women, who usually have children, tended to differ from those who are single and childless. The results of the focus group, informal interviews, and participant observation show that a number of women with children in both villages experienced problems associated with the reproductive system. Nevertheless, despite the fact that these women were married and had undergone childbirth, they were reluctant to discuss such issues with one another. As explained in Chapter 4, the majority of women tended to avoid this topic although they would be willing to discuss it with people they were familiar with.

As regards male villagers, it was found from the interviews that the main problem related to single men's risky, unsafe sexual habits (particularly teenagers in the non-remote village). It seems to be a common practice for these young men to drink alcohol together and, given the non-remote location, pay visits to nightclubs and bars where they can easily find female escorts. It is important to note that while this type of behaviour is largely acceptable for single men, it is forbidden for single women. The issue is closely linked to gendered perceptions of appropriate behaviour and the dissimilar ways of bringing up male and female children, which will be discussed in the final section.

### *Education level*

The data in the table 5.1 indicates that the majority of participants have a comparable socio-demographic profile with the exception of their education level. The informants from the remote village were found to be less educated than those of the non-remote location. In particular, 35.2% of participants from the remote village never had any formal education and the percentage of those who completed primary education was less than half of that of participants in the non-remote location (87.2% in *Baan* non-remote and 48.4% in *Baan* remote).

Previous research on medicine utilisation in Thailand revealed that education level had a significant impact on attitudes towards healthcare. For instance Tangcharoensathien (1996) argues that less educated people have a greater tendency to purchase medicine themselves rather than visit a doctor. However, the current study discovered that the



villagers' habits regarding medicine purchase in both villages did not differ significantly, despite the dissimilar education levels. This was not due to differences in access to medicines as in both locations, there are small corner shops that provide basic medicine which can be acquired without prescriptions. The only difference is that the villagers in the remote location possessed an additional alternative of purchasing traditional remedies from 'herbal experts' in the village and they also had greater access to peripatetic drug vendors who sell medicine in distant places than those in the non-remote location.

One interesting difference was that some people in the remote location appeared to have a greater opportunity to obtain training that was not provided by the government but had a direct effect on villagers' healthcare access. Common examples include learning about herbal remedies, acupuncture, and first aid, as well as how to inject medicine and administer intravenous drips. The researcher had a personal experience of being treated by the villagers after having an ankle injury as a result of an accident that took place before arriving at the village. Even though the researcher was treated by a hospital physiotherapist several times to ensure that the injury had healed, during the period of data collection, the researcher's ankle became painfully swollen. The researcher therefore decided to obtain acupuncture from a 'village doctor' and found it to be highly satisfactory after only three treatments. The service was provided for what seemed a very low price to the researcher i.e. 100 Baht or around 2 pounds for each treatment, but not to the villagers, as the daily wage was around 3 pounds.

This example shows that despite limited education, the villagers were highly self-sufficient in terms of healthcare, which partially explained why they might not need to be reliant upon the government healthcare system. In certain cases, it was found that the villagers effectively combined their existing knowledge with modern medicine. For example, an elderly female villager in the remote location informed the researcher that she tended to rely on medical doctors primarily for the diagnosis. Once the illness had been diagnosed, she would then acquire treatment from a 'herbal expert' in the village who would provide her with traditional remedies. Thanks to this combined approach, she could avoid frequent long-distant travelling. Details of the villagers' self-sufficient healthcare system, which significantly enhances their wellbeing, will be presented later in the chapter.

### **5.4.3 Economic**

From table 5.1, it can be seen that both the income and expenditure levels of villagers in the non-remote location are higher than those in the remote village. The difference regarding sources of revenue and spending also reflects dissimilar lifestyles of the two groups. As mentioned above, the major source of earnings of the non-remote village is off-farm income whereas people in the remote location are largely dependent upon the sale of agricultural products. Although both groups spend most money on food, the amount is significantly greater for the non-remote location (approximately 2.7 million as opposed to 1.9 million Baht), which can be explained by the fact that people in the remote village possess better access to natural sources of food.

In relation to savings and debt, it was found that the majority of research participants did not have any savings. Moreover, the aggregate amount of debt substantially outweighed savings in both villages. Nonetheless, it was found that the villagers in the remote location possessed a larger amount of debt than those in the non-remote village, most of which was related to agriculture.

The type of healthcare access can be indicated by the amount spent on healthcare. The villagers in the non-remote location spend proportionately three times as much as those in the remote location on healthcare (twice as much in terms of actual expenditure). While people in both groups have low-priced access to UC services and it is more convenient for those in the non-remote location to utilise the healthcare services, the amount of healthcare spending is considerably higher in this village. This reflects the more limited use of the UC card and can be potentially explained by three factors.

The first factor is fundamentally related to the villagers' occupations. The majority of participants from the non-remote location work outside the agricultural sector thereby having more limited time to attend health services than those who do farming. Secondly, the fact that people in the remote village have greater debt and a lower income level than their non-remote counterparts could represent one of the reasons why there is a stronger need to save and not spend much even on healthcare. Lastly, the relative absence of private clinics in *Baan* remote is also important. However, these two potential explanations are merely initial observations. The issue will be discussed in greater detail in Chapters 6 and 7.

#### 5.4.4 Culture and lifestyle

The culture and lifestyle of villagers from both sites are closely related to the locations of their villages. Based on the data on occupation, education level, source of income and other factors mentioned above, it could be argued that the non-remote village is already partially urbanised. The change has both direct and indirect effects on healthcare access. The direct effect is a greater variety of alternatives in terms of healthcare service as mentioned above whereas the indirect effect reflects different lifestyles and occupation, as well as greater exposure to information from various sources. As a result, the long-established culture of the village has been significantly infused with a more contemporary ethos.

One example of this shift is the disappearance of village midwives and the ‘*Yuu fai*’ tradition among women in the non-remote village. The ‘*Yuu fai*’ refers to a long-established custom practised by women after childbirth which involves staying near a fire in order to help the womb dry and clean itself. During the ‘*Yuu Fai*’ period women drink hot water and have hot showers (both drinking water and shower water are boiled with herbs). Many foods are banned during this period due to ‘taboos’ or ‘*Ka-Lam*’ as known in the *Isaan* language (Researcher’s field notes, 2005). In contrast, both village midwives and the ‘*Yuu fai*’ tradition continue to be important in *Baan remote*.

Figure 5.22 A ‘*Yuu fai*’ and 5.23 example of herb that women drink during ‘*Yuu fai*’ period.



Source: The researcher’s own picture

The second example is the acceptance of novel values and attitudes such as an awareness regarding the importance of exercise as distinct from daily activity. From the interviews it was found that while health promotion initiatives such as aerobic dance classes appeared to produce positive effects in the non-remote village, it failed to create any results in the remote location where it was viewed as ridiculous, as explained earlier in this chapter. Another illustration relates to gender, specifically preferences for male or female infants (see Table 5.4).

Table 5.4 Preference for sex of a child

Item	Baan non-remote		Baan remote	
	N (94)	%	N (94)	%
Which sex would you prefer for your first child?	48	51.1	65	53.3
1. Male	28	28.8	37	30.3
2. Female	18	19.1	20	16.4
3. Either				
Which sex would you prefer for your next child?	21	22.3	30	24.6
1. Male	49	52.1	74	60.7
2. Female	24	25.5	18	14.7
3. Either				
If you have only one child, which sex would you prefer?				
1. Male	26	27.6	49	40.2
2. Female	44	46.8	24	36.1
3. Either	24	25.5	29	23.8

Source: Researcher's questionnaire surveys 2005

Table 5.4 illustrates that more than half of villagers in both villages would like their first child to be male and the second child to be female. The reason for having a boy as the first child in the family was because a male descendant could help with father's tasks such as working in the rice fields. The female baby was selected as the second choice for helping with the mother's tasks such as housework, cooking, cleaning (i.e. traditional female reproductive roles)

However, when villagers were asked if they could have only one child in their family, which sex they would prefer, the answers were very different. Interestingly, villagers in *Bann* non-remote preferred to have a girl rather than a boy, whilst villagers in *Bann* remote preferred a boy rather than a girl. Villagers in *Bann* non-remote gave two main reasons which are, firstly, a girl receives dowry when marrying and secondly they can

help the family economically. As villagers in *Bann* non-remote are by definition non-remote area there are more opportunities for women in the urban centre and in particular in the industrial sector. Many of the women in *Bann* non-remote earn money from working on subcontracted jobs in factories, particularly the fishing net factory, and younger women also work in factories. In *Bann* non-remote, women's role as an income earner is clearer than *Bann* remote therefore perceptions of gender roles in *Bann* non-remote are linked with the idea that women can be economically productive.

These examples illustrate that preferences for male or female infants are closely associated with the social and economic role of women and men. In order to understand the way in which gender influences access to healthcare, it is necessary to explore the gender culture that characterised the two villages. In the two research sites, the significance of being male or female was strongly associated with the respective social and cultural contexts and most males and females were socialised differently. Most males were taught to be the leader of the family, whereas most females were trained to be responsible for the family's wellbeing. Being a 'real man' translated as '*Luk Phuchai*' and was defined as the opposite of being a '*Luk Phuying*' or 'real woman'. Focus groups among women and men in both villages described how '*Phuchai*' meant father and son and '*Phuying*' meant mother and daughter. This separation of roles was reinforced when villagers taught their children in the same ways as they had been taught by their own parents.

Another vivid example of how location and lifestyle are important factors that affect the villagers' healthcare access is found in *Bann* remote. For *Baan* remote, lack of accessibility caused by the substantial distance to the health centre has led to the remote villagers having to rely on their own medical care, as they have had to do in the past, particularly during their exile in the late 1970s. They have learned herbalism, acupuncture, and even how to administer glucose drips, from their time living in the forest. In addition, they have made use of other traditional treatments, including using local midwives and 'spiritual dance'. In this context, the in-depth interviews and participant observation revealed that many villagers in this village had been using their own medicines, such as those made from herbs on an everyday basis (Researcher's field notes 2004 and 2005). One key reason why many in this village relied on themselves for their own treatment was because of their high levels of confidence in their knowledge and expertise in administering medical care.

The remote villagers have not only developed a strong ethos of ‘self-help’ healthcare, but they have also provided medical support to people suffering HIV and AIDS. Many of these people have been rejected by families in other part of Thailand, and in this particular village they have established a healthcare centre for AIDS patients called ‘*Arokayasom*’, which means ‘ a place without disease’ in Pali. The centre has become well-known for its use of many traditional medicines and holistic treatments, including: herbs from the forest, Chinese acupuncture and meditation. In fact, in 1998 -1999 the MoPH provided funding support for the centre. However, this was withdrawn and the project closed after the embezzlement of funds by one of the managers (Researcher’s field notes, 2005).

In addition to their medical care, the villagers receive assistance from a local, well-respected monk named *Pra Ajarn* Band. A number of doctors from Bangkok who respect *Pra Ajarn* Band organise a free mobile healthcare service that operates once a year at a school near the health centre. In year 2005 approximately 2000 people (see pictures below) went to the mobile healthcare facility, including villagers from *Baan* remote (Researcher’s field notes, 2005).



Figure 5.24 Villagers queue to receive free healthcare



Source: The researcher's own picture

Figure 5.25 Most of the queuing villagers are women



Source: The researcher's own picture

## 5.5 Conclusion

This chapter has given a description of the characteristics of the villagers and the two villages in Northeast Thailand or Isaan. Historically, Isaan has been closely related to Laos and many people in Isaan have felt that they are treated differently from the rest of the Thai nation. In addition, it has the highest rate of poverty, one key reason for this being the possession of poor natural resources and limited infrastructure. In the 1970s this region was involved with the communist movement in Thailand and since then, many development projects have been implemented in the region, partly in order to limit support for the communist uprising. Recently, this region has been seen as a main support base for the TRT and the PPP party and the UC scheme has been cited as one of the key reasons why Isaan has supported these parties.

The two villages of this research are located in the same region, but the non-remote village has comparatively better economic development and health infrastructure than the remote village. Although agriculture is ostensibly the main occupation for the two villages, the main sources of income are different. That is, the main sources of income in the remote village are more agriculturally-based than in the non-remote village. It was found that the largest expenditure in both villages was on food; however, the non-remote villagers, on average spent twice as much than the remote villagers, because the latter relied more on natural food sources, which were more abundant.

In terms of health expenditure, it emerged that more than 90% of the non-remote villagers paid for healthcare, compared to only 31 % of the remote villagers. Moreover, although the non-remote villagers paid twice as much as the remote villagers for health services, the latter had average travel cost that were five times as high as those of the former. When comparing the villagers' accessibility to healthcare, it was found that the non-remote villagers were more privileged in being able to access multiple healthcare facilities, including using the UC card with lower travel costs and times. That is they had fewer extra costs of healthcare than the remote villagers.

The next two chapters employ a WFE, which developed from literatures and theories described in Chapters 2 and 3, to investigate how the villagers use the UC scheme.



Whilst Chapter 6 focuses on the uptake and usage of the UC card, Chapter 7 considers the contribution the UC scheme to villagers' satisfaction levels.

## **Chapter 6: Uptake and Using the UC scheme**

Referring back to the WFE approach introduced in Chapter 3, this chapter applies it to analyse the data to explore how the UC scheme has contributed to villagers' wellbeing in the two villages of this study. It does so by focusing on the different dimensions identified in the WeD's 2007 definition of wellbeing (Gough and McGregor, 2007), this being: 'a state of being with others, where human needs are met, where one can act meaningfully to pursue one's goals, and where one enjoys a satisfactory quality of life' (see Chapter 1 page 22). This definition of wellbeing highlights three main dimensions, that is: the material, the relational and the affective/cognitive aspects (WeD 2007). Therefore, these three inter-related dimensions need to be taken into account in order to assess or understand wellbeing.

To discuss how the UC scheme has affected villagers' wellbeing, this chapter considers the first two aspects in the above definition of wellbeing, i.e. satisfying needs and being able to act meaningfully to pursue one's goals, whilst the next chapter focuses on the analysis of satisfaction from the UC scheme and the extent to which contributes to people's satisfaction with life, in general. This chapter also focuses on the uptake and utilisation of the UC card, in order to analyse the extent to which villagers' healthcare needs are being met and the ways in which the UC scheme enables them to act meaningfully to pursue their health goals. The chapter is divided into four sections as follows:

Firstly, villagers' diverse understandings of the value of health are explored, in relation to the understanding of health implicit in the theory of human need (Doyal and Gough, 1991). Secondly, the uptake of health provision is considered with an explanation of the eligibility criteria for obtaining a UC card and the presentation of the evidence on the uptake of UC cards by the villagers in the research sites. In addition, this section focuses on who had and who did not have the UC card and why that was. Thirdly, villagers' experiences of using or not using the UC card are investigated, including a discussion of the form of healthcare provided under the UC scheme. The last section contains the conclusion.

All the dimensions described above are discussed using both qualitative and quantitative data, which includes: questionnaires, focus groups, and in-depth interviews and the data is analysed by the villagers': location, gender, age and economic status.

## 6.1 Understandings of health

### 6.1.1 Affirmation of the importance of health

The findings from people of all classes, gender and age in *Baan* non-remote and *Baan* remote show that villagers agreed that health was an important factor for their wellbeing and that being in good health was one of the most essential requirements for their lives. In other words, good health was considered to be a basic need and being in good health helped them to be happy and content. This result is supported by the findings of many scholars, for example, having good health has been ranked as one of the top five areas for Thai villagers ( Jongudomkarn and Camfield 2006). The work of Woodcock *et al.* 2007 and Camfield *et al* 2009 affirmed the importance of 'having good health' as the highest desired goal for villagers, as shown in the table below where only one person described health as 'not necessary'.

Table 6.1 Goal necessity item responses (51 items in WeDQol –Thailand)

Goal necessity item	Necessity Rating Frequencies (%)					
	Not Necessary		Necessary		Very Necessary	
	N	%	N	%	N	%
1.Having good <b>health</b>	1	0.3	34	9.2	331	90.5
2.Having enough <b>food</b>	3	0.8	47	12.7	319	86.4
3.Having <b>water</b>	0	0	56	15.2	313	84.8
4.Having good <b>family relations</b>	2	0.5	56	15.2	311	84.3
5. Having a <b>room or house</b>	4	1.1	55	14.9	310	84.0

Source: Camfield *et al* 2009

Note: presents the five most frequently endorsed items from a total of 51 items.

As stated in Chapter 3, Thai people perceive that ‘having good health<sup>57</sup>’ is valuable for a number of reasons. They believe in ‘*Khwarm mai mee rok pen lap an prasert*’, which can be translated into English, as ‘lack of disease is precious luck’. Another saying among villagers is ‘*Sookaparb dee mee kha gwa nguen thong*’ which means ‘health is better than money’. These sayings reflect how being healthy is linked to being lucky and how health is seen as much more important than having money by many Thai people.

The significance of good health also forms part of the villagers’ fundamental religious beliefs. The example below is from an old woman from *Baan* non-remote who said that every time she makes merit, she always prays for good health, free from illness:

When I ‘*Tam Boon*<sup>58</sup>’, I always pray that I am healthy, never falling ill. If I will be very ill, I prefer to die fast rather than having to suffer for long. I’m not asking for this in the next life, but in this present life  
(Female, 61 years old 23 November 2005)

These examples are supported by the quantitative data analysis. When the villagers were asked to define the word wellbeing, most of them in both sites associated the term with health and wealth. The results show that a large number of villagers ranked good health higher for achieving wellbeing (61.7% in *Baan* non-remote and 66.4% in *Baan* remote, respectively) than wealth (53.2 % in *Baan* non-remote and 35.3 in *Baan* remote, respectively). These results are in line with a study on the Quality of Life in Thailand which also found that health was ranked higher than income (Jongudomkarn and Camfield, 2005).

Many of the villagers interpreted good health as including both good physical and mental health. Good physical health was spoken about in both positive and negative ways, such as: ‘having the energy to work’, and ‘having no disease’. Similarly, regarding good mental health phrases like: ‘having a clear mind’, ‘being happy with life’ and ‘having no worries about things’ were offered by the villagers. It can be seen

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<sup>57</sup> There is a different language between Thai and English. For example while Thai people see health as ‘having’, in English health is seen as ‘being’, such as I am well refers to I ‘being in good health’ and able to do activities. For Thai people good health is something that can be acquired and which enables them to do activities. Thus in this sense ‘having good health’ means the same as ‘being in good health’ in English.

<sup>58</sup> Usually refers to the Thai Buddhist ceremony whereby one receives merit by offering food to monks.

that while good physical health is related to acting or doing, good mental health is concerned more with ‘thinking’. In other words, how the villagers feel about their life.

The importance of ‘having good health’ is also emphasised in *Isaan* culture. In Thai society a seniority system is practiced, and in *Isaan*, as in as the other regions of Thailand, people pay respect to those who are older than them and especially to the elderly. When the elderly bless their descendants or visitors, they always use the local phrase ‘*Kor Hai Yu Dee Mee Hang*’, which translated literally in English means ‘may you live well, having energy’. The ceremony below performed by villagers to bless the researcher. The white string is tied to bring about a good spirit and to symbolise a wish for ‘*Yuu Dee Mee Hang*’.

Figure 6.1 A ceremony for ‘*Yuu Dee Mee Hang*’



Source: The researcher’s own picture

One of the villagers explained that ‘having good health’ and ‘having energy’ are actually similar, because when one is healthy one can eat and sleep well and this contributes to one having energy and a happy life. So, both phrases in fact have the same meaning.’ (Female focus group in *Baan* non-remote, 8 December 2004) The examples above suggest that people perceive a link between ‘energy’ and ‘living well’.

In terms of the relevant literature, as discussed in Chapter 3, the importance of health has been expressed as having a number of different meanings. For example, the Resource Profiles Approach (Lewis *et al.*, 1991; Lewis and McGregor, 1992) has classified 'good health' as a human resource and suggested that 'good health' plays an important role in the 'good life'. Doyal and Gough (1991) pointed out that health is a basic human need, being one of two fundamental needs alongside autonomy. Obtaining this basic need can contribute to the achievement of a good life, for example, it can allow for participation in social activities. More importantly, according to the respondents for this research if people's objective is to live well, good health and having energy are strongly linked and can contribute to the achievement of a good life.

### **6.1.2 Different perceptions of the value of 'having good health'**

Although most people value 'having good health' as a high priority, their views on the reasons for valuing health differ and the most visible differences in the villages of this study were according to age and gender. From the in-depth interviews, many elderly people emphasised being mobile and being able to eat and sleep. For example, one elderly woman from *Baan* non-remote expressed her view on health as:

Health is important to me. It makes me happy and contented. When I am healthy, hearing people play the 'Can' [a traditional music instrument] is beautiful. But when I was sick, music was sad, it did not sound as nice. When you are healthy, you have an appetite for food and can go anywhere. Now I am better, I can exercise and do some housework.' (Female, 61 years old 23 November 2005).

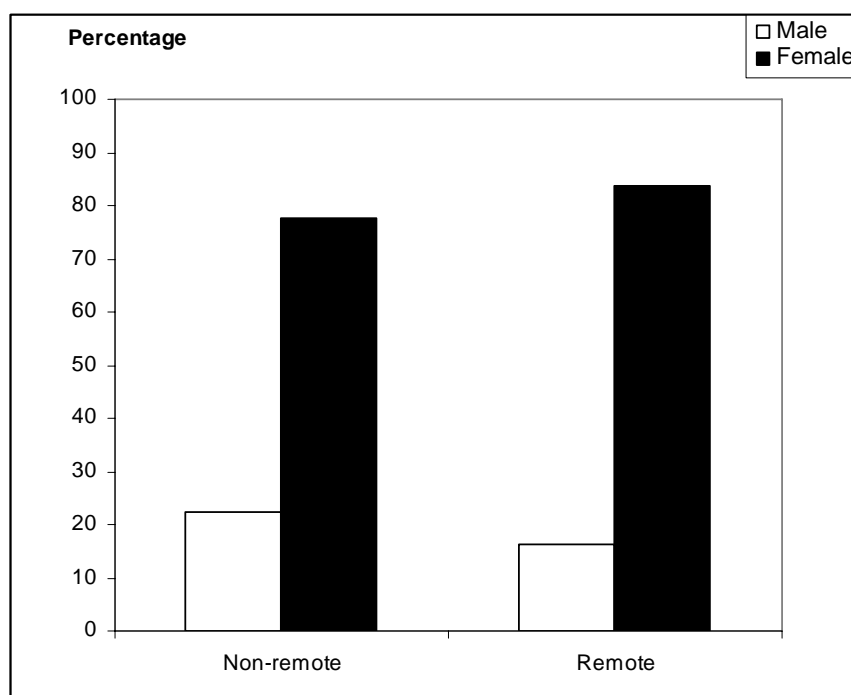
In contrast, young people valued health for different reasons. This is because it helped them to have a good job which led to greater financial security for their family. As one young female from the same village suggested:

'If we are healthy, we will have courage to do work. Good health makes us feel motivated to work. I feel valuable when I go to work. Now I'm healthy I can go to work. I don't get sick that much and that makes me and my family feel happy and comfortable with our lives' (Female, 18 years old 26 November 2005).

The examples above have shown how age plays a role in respondents' views on health. The elderly woman saw health as a basic need in order to enjoy a good life, whereas the younger woman viewed it as a resource, which enabled her to work towards a better standard of living.

Gender differences were also visible, in that women placed a higher value on having good health than men. Data from the questionnaire shows that most villagers in both villages agreed with the statement that, in general, women take better care of their health than men: 77.7% in *Baan* non-remote and 91.0% in *Baan* remote (Chart 6.1).

Chart 6.1 Percentage of Male and Female Views on Health Behaviour in *Baan* non-remote and *Baan* remote



Source: Researcher's questionnaire surveys 2005

Data from the focus group discussions among women and men in each village also demonstrate the different attitudes to health held by men and women, although these are by no means universal. However, they do explain, to some extent, the different types of health-seeking behaviour among women and men and thus the different level of usage of the UC card, as shown by the following:

‘If men go to see a doctor often, they are thought of as weak and less manly’  
(Male focus group 5 December 2004).

‘Men will go to doctors only when they are almost dead and in many cases they  
are too ill to be cured’ (Female focus group 8 December 2004).

The perception of gender and health will be discussed in greater depth in Chapter 7 page 281-282 when how gender relates to villager’s healthcare utilisation is considered.

From the villagers’ point of view, ‘having good health’ is essential for their lives, in other words it is seen as a goal to strive for. In order to analyse the extent to which villagers’ healthcare needs are being met, this researcher employs Doyal and Gough’s theory of human needs (THN) (1991). According to this theory ‘appropriate healthcare’ is an intermediate need or ‘need satisfier’ which is viewed as a means of promoting a better quality of life, as it enables people to participate more fully in social life. This leads to the question: if villagers have a goal of achieving good health, does the UC scheme make it more possible for them to succeed in this aim?

In order to answer this question, it is necessary to analyse the ‘needs’ together with ‘meaningful action’. According to Gough and McGregor (2007), people always engage in meaningful actions, in that they usually behave according to their: values, goals and identities, which often vary from individual to individual, as explained earlier (see Chapter 3 page 130). The WeD project has defined meaningful actions as those that occur when people are in control of their lives in relation to their goals. However, individuals have different opportunities or choices, as suggested by Sen (1999), in that these choices are dependent on their capabilities and are restricted by their circumstances. Therefore, it is necessary to examine whether the UC scheme has opened more doors for the villagers, thus enabling them to have greater capability of acting meaningfully towards their health goals. In this vein, two key questions need to be investigated: Have the villagers taken up the UC card? If they have, have they been using it (utilisation)?



## 6.2 Uptake of health provision

In order to investigate whether the UC scheme has enabled villagers to act meaningfully in pursuit of their health goal, that is, whether it has provided additional options for achieving healthcare access, it is necessary to assess the level of uptake of the UC card. This can be investigated by considering to key factors: eligibility for the UC card and what types of people at the sites have taken up the card.

### 6.2.1 Eligibility

The right of access to free healthcare was addressed in the UC scheme's regulations and eligibility for possessing a UC card was made dependent on several criteria. However, the main criteria for qualifying for the scheme are that participants must be Thai citizens who were uninsured and not covered by any other forms of healthcare, such as the Civil Servants Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS). Those eligible include: children under 12 years old, the elderly over 60 years old, people with disabilities, lower income families and individuals, monks, leaders of communities and village health volunteers. When the people who qualify enrol in the UC system, they receive benefits offered in the Medical Benefits Package, as was explained in Chapter 2. The package consists mostly of access to minor or major surgery and other outpatient and inpatient services at a network of private and public hospitals (for details see Chapter 2).

Table 6.2 indicates that the majority of the respondents (83.2%) in both villages who were eligible had the UC card. Although all the eligible villagers have been given the right to access the UC scheme since 2001, not everybody at the time of the survey in 2005 had acquired a UC card. The number of UC cardholders in *Baan* non- remote was found to be higher than in *Baan* remote by approximately 10 %. This result illustrates that the non-remote village still had potentially better access to the UC scheme, even though the government has been committed to providing equal access to the programme in all areas since 2001.

Table 6.2 The eligibilities and percentage of the UC card possession by **location**

Location	The UC card				Total	
	Have		Do not have			
	N	%	N	%	N	%
1. <i>Baan</i> non-remote	743	88.9	92	12.1	835	100
2. <i>Baan</i> remote	740	78.1	208	21.9	948	100
Total	1483	<b>83.2</b>	300	16.9	1783	100

Source: *Baan* non-remote and *Baan* remote's healthcare centre 2005

This data suggests that even though the eligible villagers had been given the right to access the UC cards, this does not necessarily mean that everybody would have had one. Table 6.2 indicates that some villagers did not have the card and the following section describes who these villagers were, in terms of their: location, age, gender and socio-economic status.

### **6.2.2 Who had the UC card and who did not?**

This section describes the UC card holders in relation to location, gender, age and class as follow.

#### **6.2.2.1 Location**

Two types of UC card were provided to Thai people in the two research villages: the co-payment card and the free card. Table 6.3 shows the percentage distribution of the different types of UC cards in the two villages. It was found that in both villages the amount of free card holders was double that of co-payment card holders (66.7% vs. 33.3%). In addition, the proportions of the villagers who had co-payment or free UC cards were roughly the same in both villages, despite the different level of uptake, as shown in Table 6.2.

Table 6.3 Percentage of the different types of UC card holders by **location**

Location	Type of Card				Total	
	Co-payment card		Free card			
	N	%	N	%	N	%
1. <i>Baan</i> non-remote (N=94)	31	33.0	63	<b>67.0</b>	94	100
2. <i>Baan</i> remote (N=122)	41	33.6	81	<b>66.4</b>	122	100
Total	72	33.3	144	<b>66.7</b>	216	100

Source: Researcher's questionnaire surveys 2005

### 6.2.2.2 Gender

Similar to the findings regarding location, the majority of villagers held the free card. In terms of gender, Table 6.4 shows that for both sexes the number of free cardholders was greater than that of the co-payment type, with a slightly higher percentage of women holding the free card than men in both villages.

Table 6.4 Percentage of the different types of UC card holders by **gender**

Gender	Type of Card				Total	
	Co-payment card		Free Card			
	N	%	N	%	N	%
<i>Baan</i> non-remote						
1. Male	17	36.2	30	<b>63.8</b>	47	100
2. Female	14	29.8	33	<b>70.2</b>	47	100
Total	31	33.0	63	67.0	94	100
<i>Baan</i> remote						
1. Male	23	33.7	38	<b>62.3</b>	61	100
2. Female	18	29.5	43	<b>70.5</b>	61	100
Total	41	33.6	81	66.4	122	100

Source: Researcher's questionnaire surveys 2005

### 6.2.2.3 Age

As far as age is concerned, the proportion of free card holders again is comparable to the results reported earlier and as Table 6.5 demonstrates the majority of people in every age range, in both villages, had the free card rather than the co-payment card.

Table 6.5 Percentage of the of different types of the UC card holders by **age**

Age	Type of Card				Total	
	Co-payment card		Free Card			
	N	%	N	%	N	%
<i>Baan non-remote</i> (N=94)						
1. Young	0	0	2	<b>100.0</b>	2	100
2. Middle-aged	28	40.0	42	<b>60.0</b>	70	100
3. Old	3	13.6	19	<b>86.4</b>	22	100
Total	31	33.0	63	67.0	94	100
<i>Baan remote</i> ( N=122)						
1.Young	6	31.6	13	<b>64.8</b>	19	100
2. Middle-aged	32	33.7	63	<b>63.3</b>	95	100
3. Old	3	37.5	5	<b>62.5</b>	8	100
Total	41	33.6	81	66.4	122	100

Source: Researcher's questionnaire surveys 2005

Regarding the results in Table 6.5, there are two important issues that to be taken into account. Firstly, in the two villages the age groups were not evenly proportioned. For example, in *Baan remote* there were only eight old people compared to 95 middle-aged, while in *Baan non-remote* there were only two people in the youngest group. This limits the conclusions that can be drawn about differences in card holding by age. The surprisingly small number of people in the youngest group in *Baan non-remote*, is explained by the fact that most of them were employed in the local factories and so were already insured by the SSS cards (RANQ 2004 and Researcher's questionnaire 2005). Therefore, figures for this group being meaningless, are disregarded and no conclusion can be drawn for them. However, the rest of the results for both villages, in general, appear to offer some tentative observations. It was found that in the non-remote village the elderly was the group with the highest percentage of free card ownership (86.4%),

whereas in the remote village 64.8% of young people who had cards had a free card, and the proportions for the other two age groups, that is the middle-aged and the elderly, were similar, being 63.3% and 62.5%, respectively.

Secondly, according to the UC regulation, people who are older than 60 are classified as ‘elderly’ and should therefore be provided with a free UC card. However, Table 6.5 shows people in this age group, three in each village, were holding a co-payment card, which indicates that there were errors in providing cards in both villages.

#### 6.2.2.4 Economic class

As explained in Chapter 4, respondents were grouped into three economic classes during the first round of the fieldwork: poor, middle, and rich (see Chapter 4 page 151). Table 6.6 illustrates that in both locations the middle economic class and the poor represented the group that carried the greatest number of free cards (73.1% in *Baan* non-remote vs. 71.2% in *Baan* remote, respectively). Regarding type of card, it can be seen that the villagers from the rich economic class, in both villages, were in possession the highest percentage of the co-payment cards compared to free cards. That is 64.3% of the rich card holders in *Baan* non-remote and 50.0% of those in *Baan* remote had co-payment cards.

Table 6.6 Percentage of the different types of UC card holders by **economic class**

Economic class	Type of Card				Total	
	Co-payment card		Free Card			
	N	%	N	%	N	%
<i>Baan</i> non-remote(N=94)						
1. Poor	8	28.6	20	71.4	28	100
2. Medium	14	26.9	38	73.1	52	100
3. Rich	9	64.3	5	35.7	14	100
Total	31	33.0	63	67.0	94	100
<i>Baan</i> remote( N=122)						
1.Poor	15	28.8	37	71.2	52	100
2. Medium	20	34.5	38	65.5	58	100
3. Rich	6	50.0	6	50.0	12	100
Total	41	33.6	81	66.4	122	100

Source: Researcher's questionnaire surveys 2005

As noted above, the purpose of the UC scheme is to assist people who cannot access healthcare, owing to economic constraints. The findings in Table 6.6 illustrate that the distribution of the free card to the poor and the medium economic class is more common than for the rich and hence this group have easier access to the UC scheme.

### **6.2.3 Explanation for non UC card holders**

Despite the fact the results in the previous section show the majority of eligible villagers were in possession of cards and the main emphasis of this thesis is focussed upon these villagers, it is also necessary to consider those who did not have either card. Therefore, this section explores the different reasons why certain groups of villagers were excluded, in spite of the fact that they had been entitled to the UC card for the previous three years before the study was conducted. The explanation for the non take up in both villages could be attributed to two key factors. The first relates to the villagers' own decision not to acquire the cards and the second was down to bureaucratic failings.

The first explanation involved a variety of factors, these being: economic, e.g. the cost of travelling to the health centres, or geographical, e.g. distance from the health service providers. These factors emerged as being particularly significant in a case of *Baan remote* and discouraged some people from applying for cards, with them preferring to rely on traditional medicine.

The second important factor that led to the non take up of UC cards, relates to the poor management of the scheme by the local authorities and this was found to have affected the villagers detrimentally at both sites. In *Baan remote*, some villagers belonging to the poor economic group who were entitled to free services were wrongly offered the co-payment cards. In addition, the same error had occurred amongst the older inhabitants in both villages, in that were only offered the co-payment of cards instead of a free card. As a result, many of these people had been discouraged from obtaining the cards and thus participating in the scheme.

The specific reasons for each village that appear to explain the non-card take up are detailed as follows:

### **A) Baan non-remote**

Two explanations were specific to *Baan non-remote* for not having card. Firstly, some of the non-card holders were those who had been migrating to find employment elsewhere. For instance, some of the villagers regularly went to work as sugar cane cutters in Kanjanaburi and Rajaburi following the harvesting season (from the end of November to the end of April) and if they had any health problems whilst they were away, they were told by their employer that s/he would take care of them. As one respondent put it during the interviews:

‘The boss will give us 500 Baht in case of accidents or emergencies. If we need to see a doctor, we can also ask him. In case of death, he will offer 1,000 Baht as financial support.’ (Female, 49 years old, 18 January 05)

This quote indicates that the migrants may not feel that they need to have a UC card, because of the existence of these and other informal welfare practices.

Secondly, some of the non-card holders were the unemployed and expected to return to work shortly. They knew that when they eventually got new jobs in a factory they would get an SSS card and in the meantime expressed the view that it was too much of a nuisance getting a UC card.

### **B) Baan remote**

As for *Baan remote*, the first explanation for people not possessing cards related to the ineffective management system of the cards. For instance, the distribution of the free cards was based on a ‘first come, first served’ basis devised by the healthcare workers. This system had the aim of making it easier for the villagers to get card, as it was delivered within the village and meant that people did not have to travel to the healthcare centre 15 kilometres away. However, it was discovered that this system created confusion and dissatisfaction among villagers as the cards did not always go to those who needed them most (Researcher’s field note 2005). For example, it was found that villagers who were eligible for free cards were sometimes allocated co-payment cards instead, which they refuse to go to collect (Researcher’s field note 2005).

The second explanation is associated with the issue of opportunity cost (Bunchanan 1969), which refers to the value that people were losing by choosing something else. That is to say, although the village was only 15 kilometres away from the healthcare centre, which might not seem to be far for the villagers, travelling to obtain the cards in person was viewed a waste of their time when they could be earning money or doing something meaningful for themselves. In this situation, the villagers chose not to collect their cards because they are considered to be ‘not worth it’.

In conclusion, the findings on uptake of the UC card have illustrated that the vast majority of eligible villagers had participated in the UC scheme by taking up cards. Moreover, this uptake was comprehensive, in terms of: location, gender, age and economic class, although there was a small minority of non-card holders who were entitled to participate. Thus in general, the distribution UC card to different groups of people at the research sites has been quite successful, in terms of the appropriate people receiving the right card and hence being eligible for using the healthcare service. However, possession of the cards does not necessarily mean that they are being used. As Doyal and Gough (1991) pointed out, the availability of healthcare for the poor means little if people are not using it and this can be accounted for by the existence additional medical fees for treatment or geographical factors, such as long distances to health service providers. Therefore, Doyal and Gough (1991) proposed that ‘utilisation’ is a more effective criterion for measuring whether a healthcare scheme is appropriate to the citizens’ needs.

## **6.3 Utilisation of the UC card**

In order to assess whether the scheme was meeting people’s actual needs and hence contributing to their level of wellbeing, it was necessary to establish the level of card usage. This section presents the finding on the level of usage by those villagers who were in possession of either of the cards that were available at the time of the research

Although in practice, there are a variety of factors that influence villagers' utilisation of the healthcare services, the existing literature has found that: location, gender, age and economic class have proved to be the critically important issues affecting people



utilisation of healthcare services (see Chapter 2). Thus, the issues of card usage and non-card usage will be discussed in terms of this set of key factors, as in the section above on card uptake.

### 6.3.1 Location

It has been argued that geographical distance from healthcare centres is one of the main elements that affect use of medical services (Khanthachai 1983, Gwatkin 2000 and Sreamsee *et al* 2003). This view was supported in the RANQ survey (2004), where remote villagers perceived that they had lower access to adequate healthcare than those in non-remote areas. In terms of UC card usage, Na Ranong (2003) found that distance from healthcare centres was a crucial factor in rural villagers gaining access to healthcare.

Table 6.7 Percentage utilisation of the UC card by **location**

Location	Utilisation of Card				Total	
	Used		Never Used			
	N	%	N	%	N	%
1. <i>Baan</i> non-remote (N=94)	60	63.8	34	36.2	94	100
2. <i>Baan</i> remote (N=122)	90	73.8	32	26.2	122	100
Total	150	69.4	66	30.6	216	100

Source: Researcher's questionnaire surveys 2005

With regards to the current research, Table 6.7 shows that for both sites an average of 69.4 % of the villagers had used the UC card. However card usage was 10 % higher in the remote village than in the non-remote village (73.8 % in *Baan* remote vs. 63.8% in *Baan* non-remote). This finding is interesting because it would appear to contradict the position of Na Ranong (2003) as presented above, in that distance acts negatively on card usage. However, it is important to understand this finding in relation to other research outcomes, such as those of RANQ. The latter investigated a whole range of

healthcare access, whereas this research has specifically focused on the UC scheme and therefore its results do not challenge those of the earlier research.

### 6.3.2 Gender

Several research papers have suggested that gender significantly influences access to healthcare (i.e. Miles, 1991; Doyal, 1995:1998; Standing, 1997; Boonmongkol *et al* 1999; Annandale and Hunt, 2000; and DeLorey, 2003). Women, especially in developing countries, tend to have less access than men to healthcare. For example, in India women were found to have lower access to the healthcare system than men (Nussbaum 2000).

Interestingly, the findings from this research with regard to using the UC scheme as shown in table 6.8 indicate that in both in both villages more women had used the UC card than men (74.5% vs. 53.2%, respectively, in *Baan* non-remote and 82.0% vs. 65.6%, respectively, in *Baan* remote).

Table 6.8 Percentage utilisation of the UC card by **gender**

Gender	Utilisation of Card				Total	
	Used		Never Used			
	N	%	N	%	N	%
<i>Baan</i> non-remote(N=94)						
1. Male	25	53.2	22	46.8	47	100
2. Female	35	<b>74.5</b>	12	25.2	47	100
Total	60	63.8	34	36.2	94	100
<i>Baan</i> remote(N=122)						
1.Male	40	65.6	21	34.4	61	100
2.Female	50	<b>82.0</b>	11	18.0	61	100
Total	90	73.8	32	26.2	122	100

Source: Researcher's questionnaire surveys 2005

### 6.3.3 Age

In terms of age, it has been argued that utilisation of healthcare is related to this factor (Aday *et al* 1993), because people's health needs increase as they get older and also they may have more time to take care of their health. Previous research in Thailand

found that a higher percentage of the elderly used the UC card, relative to other groups (Khamnuansilapa *et al.* 2000; Benjakul 2004). In addition, the MoPH (2007) observed that Thailand is becoming an aging society owing to the increased life span of the population, which can partially attributable to a more advanced healthcare system. The MoPH survey predicted that the elderly will require a substantial amount of healthcare, because only 13% (910,000) of the seven million elderly do not have any chronic illnesses (MoPH, 2007).

The evidence from this research indicates that the majority of people in every age range, in both villages, used the UC card. However, the elderly at both sites did not prove be the biggest users of the card, in terms of percentage. Table 6.9 shows that in *Baan* non-remote the middle-aged group used the UC card more than any other (67.9 %), whilst in *Baan* remote the percentage of card usage was highest among the young (89.5%). However, when comparing the two villages' usage of UC cards it emerges that for all age categories *Baan* remote had a higher percentage of card users.

Table 6.9 Percentage utilisation of the UC card by **age**

Age	Utilisation of Card				Total	
	Used		Never Used			
	N	%	N	%	N	%
<i>Baan</i> non-remote(N=94)						
1. Young	1	<b>50.0</b>	1	50.0	2	100
2. Middle-aged	47	<b>67.9</b>	23	32.9	70	100
3. Old	12	<b>54.5</b>	10	45.5	22	100
Total	60	68.8	34	36.2	94	100
<i>Baan</i> remote( N=122)						
1.Young	17	<b>89.5</b>	2	10.5	19	100
2. Middle-aged	68	<b>71.6</b>	27	28.4	95	100
3. Old	5	<b>62.5</b>	3	37.5	8	100
Total	90	73.8	32	26.2	122	100

Source: Researcher's questionnaire surveys 2005

### 6.3.4 Economic class

As mentioned in Chapter 4, respondents were grouped into three economic classes during the first round of fieldwork (poor, middle, and rich) and two during the second phase (better-off and worse-off). The categorisation in the first round of fieldwork was based on responses to the RANQ survey question about socio-economic status. Preliminary analysis from the questionnaire found strong similarities regarding the use of the UC card by people in the middle and poor groups, which led to re-categorisation of economic class for the second round of the fieldwork. That is, instead of having three different sub-groups, economic class was divided into two sub-groups, namely the worse off and the better off when the in depth interviews were carried out (see Chapter 4 page 149).

Table 6.10 Percentage utilisation of the UC card by **economic class**

Economic class	Utilisation of Card				Total	
	Used		Never Used			
	N	%	N	%	N	%
<i>Baan non-remote(N=94)</i>						
<b>1. Poor</b>	20	<b>71.4</b>	8	28.6	28	100
2. Medium	34	65.4	18	34.6	52	100
3. Rich	6	42.9	8	57.1	14	100
Total	60	68.8	34	36.2	94	100
<i>Baan remote( N=122)</i>						
<b>1.Poor</b>	40	<b>76.9</b>	12	23.1	52	100
2. Medium	41	70.7	17	29.3	58	100
3. Rich	9	75.0	3	25	12	100
Total	90	73.8	32	26.2	122	100

Source: Researcher's questionnaire surveys 2005

Economic class is considered to be an important factor in determining access to healthcare. The UNDP (1997) reported that, in most countries the poor have less access to medical services than the rich. A substantial body of literature in Thailand has found that economic class influences access to healthcare, particularly before the UC was implemented in 2001 (Tangcharoensathien 1996, Pannarunothai and Mills 1997,

Tangcharoensathien 2002 and Jirojjanakul *et al* 2004) and in most cases, the poor paid a higher percentage of their household income towards healthcare expenses than the rich.

Table 6.10 shows that in both villages, the highest levels of UC card usage were from the poor class (71.4% in *Baan* non-remote and 76.9 % in *Baan* remote). Similar to the result reported in the previous section, the remote village is found to have had a higher rate of UC card usage than the non-remote village. In particular, less than 50 % of the rich in the non-remote location used the card.

Findings from in-depth interviews with a smaller sample support the results from the questionnaire. Table 6.11 illustrates half of the respondents in the non-remote village has had never used a UC card, whilst all the poor villagers from both locations had used them.

Table 6.11 Utilisation of the UC card by **economic class** in relation to the in-depth interviews

Economic class	Utilisation of Card		Total
	Used	Never Used	
	N	N	
<i>Baan</i> non-remote(N=12)			
1. Worse off	6	0	6
2. Better off	3	3	6
Total	9	3	12
<i>Baan</i> remote(N=12)			
1. Worse off	6	0	6
2. Better off	6	0	6
Total	12	0	12

Source: In-depth interviews in the non-remote village (23 -27 November 2005) and remote village (16 -21 November 2005)

Data from the questionnaire and in-depth interviews illustrate that the poor in both villages were more likely to use their cards than those from other economic classes, which suggests that the poor especially have benefited from the UC scheme most. This

result supports the findings from other Thai scholars who have studied the UC scheme, for example, National Economic and Social Advisory Council (NESAC), 2004; Tangcharoensathien and Prakongsai 2005; Limwattananon et al., 2007; Pannarunothai 2008; and Somkotra and Lagreda, 2008)

Most villagers in both locations had used the UC card, which suggests that it was providing substantial benefits and this appears to have been especially so in the case of the poor. Interestingly, it was the poor from the remote village who were the most prolific users of the card, even though they were less able to afford transport to their allocated healthcare provision. Therefore, as suggested in the policy documents, the UC scheme appears to have been reaching the most disadvantaged.

Although the villagers appeared to consider the UC scheme to be highly beneficial in a number ways, this does not mean they always chose to use it. In other words, in practice there was evidence of a gap between their thinking and their actual behaviour. The range of conditions that underpin the villagers' decisions to use and not to use the cards will be discussed in more detail in the next chapter.

## **6.4 Conclusion**

This chapter has analysed the extent to which the UC scheme has contributed to villagers' wellbeing by exploring uptake and usage of the UC cards. It has emerged that the scheme has improved wellbeing in relation to two of the dimensions mentioned in the introduction to this chapter, that is meeting one of the villagers' human needs, this being healthcare and enabling them to act meaningfully to pursue their healthcare goals.

Firstly, the majority of villagers in both locations had been given the right to access health insurance (83.2 %) which suggests that on the whole more of the villagers' healthcare needs were being met. The preference expressed by villagers in the questionnaire for the new card seems to confirm this. Additionally, villagers described in in-depth interviews how they felt less worried about going to see the doctor because they knew that the cost would be low. While having and using the UC card is seen as one way of maintaining good health and in particular when they fall sick, the quality of the service provided was a major main concern. This issue is discussed in greater depth

in the next chapter. Two types of card (co-payment and free) were provided for them and it was found that in both locations people were twice as likely to possess the free card as the co-payment card (66.7% vs. 33.3%). When the card holders were categorised by: location, gender, age, and economic class, it was found that the free cards were held by women and the poor in higher proportions than other economic groups and men. This suggests that the free card has been distributed to those in greatest need and it is reasonable to conclude that in terms of uptake of the UC card at the research sites, the UC scheme has been successful.

Secondly, the UC scheme has enabled villagers to act meaningfully in pursuance of their health goals. This is supported by the fact that most of the inhabitants in both villages, who held a UC card, used it (69.4%). People in the remote village had a slightly greater percentage of card usage than their non-remote counterparts. It would appear that with women and the poor holding higher levels of free cards, in terms of percentages, this encouraged them to use their cards more than any other groups. Moreover, where previously families had to collectively find the money to pay for treatment if a family member was sick, having possession of UC cards meant that the whole family benefited financially and hence the whole household would feel more secure (see Chapter 7 for more details). Given that the highest percentage of UC card usage was amongst the poor, this suggests that these disadvantaged people were not only in theory able to act meaningfully but were doing so in practice. Possession of the UC card, even if the villagers did not use it still offered the villagers more choices with regards to healthcare.

The two main reasons explaining the non take up were down to the villagers' own choices, such as: opportunity cost, distance from the healthcare centre and some villagers had migrated elsewhere and but not bothered to transfer their registration. The second key reason for non take up was related to problems regarding management of the UC scheme.

However, the study has also found that almost 31% of the villagers had never used the services offered by the UC scheme, despite the fact that they had been entitled to do so since 2001 and were in possession of the card. The next chapter will examine in greater details the reasons why the villagers interviewed chose to use or not use their card. Moreover, it investigates whether the UC scheme has increased people's level of

satisfaction with their quality of life, another important dimension of wellbeing, by considering their expressed opinion.



## Chapter 7: The contribution of the UC scheme to villagers' satisfaction

*'A contented mind is the greatest blessing a man can enjoy in this world.'*

Joseph Addison, an English poet (1672 –1719)

In the preceding chapter we have seen how the UC scheme has increased villagers' options in terms of accessing healthcare. The significant number of villagers who have made use of the UC card affirms how it has satisfied their healthcare needs and how the UC scheme has enabled them to act meaningfully in pursuit of their health goals.

The analysis in this chapter aims to understand how villagers perceive the UC scheme as contributing to their satisfaction with their life as a whole. In looking at villagers' satisfaction with the UC scheme, and its contribution to their life satisfaction, the intention is to clarify and understand the uptake and utilisation of the UC scheme. In addition, an attempt is made to achieve a better understanding of motivations in respect of the use and non-use of the card.

Drawing on WeD's definition of wellbeing (Gough and McGregor, 2007), satisfaction with life, i.e. people's evaluation of the extent to which they are experiencing well or ill being, is an important dimension of wellbeing. As we have seen in the previous chapter, owing to the importance of health in rural Thailand, satisfaction with health and healthcare can be expected to have a powerful influence on villagers' quality of life. When the UC scheme makes it possible for villagers to access appropriate healthcare and achieve their health goals, it follows that this must generate a certain level of satisfaction with their life as a whole.

There are three sections in this chapter. The first section discusses the extent of the UC scheme's contribution to villagers' satisfaction with their life. This section is divided into two subsections: satisfaction with UC scheme's provision of healthcare and the contribution of the UC scheme to the villagers' life satisfaction. The second section explores the different reasons given for the villagers' meaningful actions in using or not using the UC card. In order to reflect the villagers' own feelings and experiences, various examples from the case studies are examined. The chapter ends with relevant concluding points.

## **7.1 The contribution of the UC scheme to villagers' satisfaction**

In order to evaluate the extent of the UC scheme's contribution to villagers' satisfaction with their life as a whole, this section is divided into two parts. The first explores their satisfaction with the UC scheme as experienced through using the UC card. The second part discusses how their satisfaction with the UC card added to villagers' satisfaction with their life as a whole.

### **7.1.1 Satisfaction with UC provided healthcare**

As noted in Chapter 3 (see page 134), being satisfied with what one has or '*Por Jai*<sup>59</sup>' is a particularly distinctive value in Thai society. In addition, '*Kreng Jai*<sup>60</sup>' (see Chapter 4 page 155) is another important value and customary mode of behaviour. Both these values affect how the concept of satisfaction is understood by Thai people. Therefore, as people may not have wished to give a response that offended, it is not surprising that the best-known UC evaluation, an opinion poll carried out by the ABAC, has revealed that the level of satisfaction with the scheme was at more than 90%. Moreover, it has been suggested (i.e. Avis *et al.* 1997; Williams 1994; Williams *et al.* 1998; Staniszewska and Ahmed 1999 and Rogers *et al.* 2000) that the survey measure of satisfaction may produce results that are inaccurate and overly positive, in cultures that value positive responding (Cummins 2008) (see Chapter 3).

In order to avoid the weaknesses found in the methods of the satisfaction survey mentioned above and to enable a greater explanation of satisfaction and dissatisfaction, this study draws on the data generated from the quantitative and qualitative methods that it deployed. That is to say, the data used in reporting on people's levels of satisfaction when using the UC card are based on the questionnaire whereas reasons for being satisfied and dissatisfied with the UC scheme come from the in-depth interviews and focus group discussions.

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<sup>59</sup> '*Por Jai*' in Thai, literally meaning 'enough (for the) heart (to be happy)'. Thus in this sense '*Por Jai*' has a close meaning to 'contentment' rather than 'satisfaction' in English.

<sup>60</sup> A very Thai concept which can be translated to English as 'to be afraid of offending (one)', 'to be considerate of another feeling'

The following data tables present the villagers' satisfaction with using the UC card in the two villages. This was taken from both quantitative and qualitative analysis.

Table 7.1 Percentage of villagers' satisfaction with the UC scheme

Villagers' opinions of the UC scheme	<i>Baan</i> non-remote		<i>Baan</i> Remote		Total	
	N	%	N	%	N	%
1. Good	68	72.3	97	75.9	165	<b>76.4</b>
2. It needs to be developed	26	27.7	22	18.0	48	22.2
3. No answer / don't know	0	0	3	2.5	3	1.4
Total	94	100	122	100	216	100

Source: Researcher's questionnaire surveys 2005

The findings with regards to satisfaction with the UC scheme supported the general message given elsewhere in the national ABAC poll. The results from the analysis of the questionnaire showed that 76.4 % of villagers from both villages who used the UC card were satisfied with the UC scheme. Although 76.4 % is relatively high, it is obviously lower than the 90% reported by the ABAC poll. It can be posited that the high percentage of satisfaction found in both sites implies that most villagers were satisfied with the UC scheme.

With regards to satisfaction with the 15 issues survey in the questionnaire (see Chapter 4 on method) the villagers were asked to rate their satisfaction level for each aspect on a five point Likert's scale ranging from strongly dissatisfied (1) to strongly satisfied (5). It was found that the villagers in both villages had a similar level of satisfaction with the UC card. The mean satisfaction scores of the villagers in *Baan* non-remote and *Baan* remote were relatively high at 3.9 and 3.5 out of 5, respectively.

In terms of the distribution of satisfaction, results show that the majority of respondents from both villages reported that they were satisfied with the UC card, 96.7 % in *Baan* non-remote and 65.6 % in *Baan* remote (see Charts 7.1 and 7.2). Considering the distribution trend, the evidence in both charts demonstrates positive skewing, however, there is greater variation in responses in the remote village.

Chart 7.1 Distribution of total satisfaction on using UC card in non-remote village

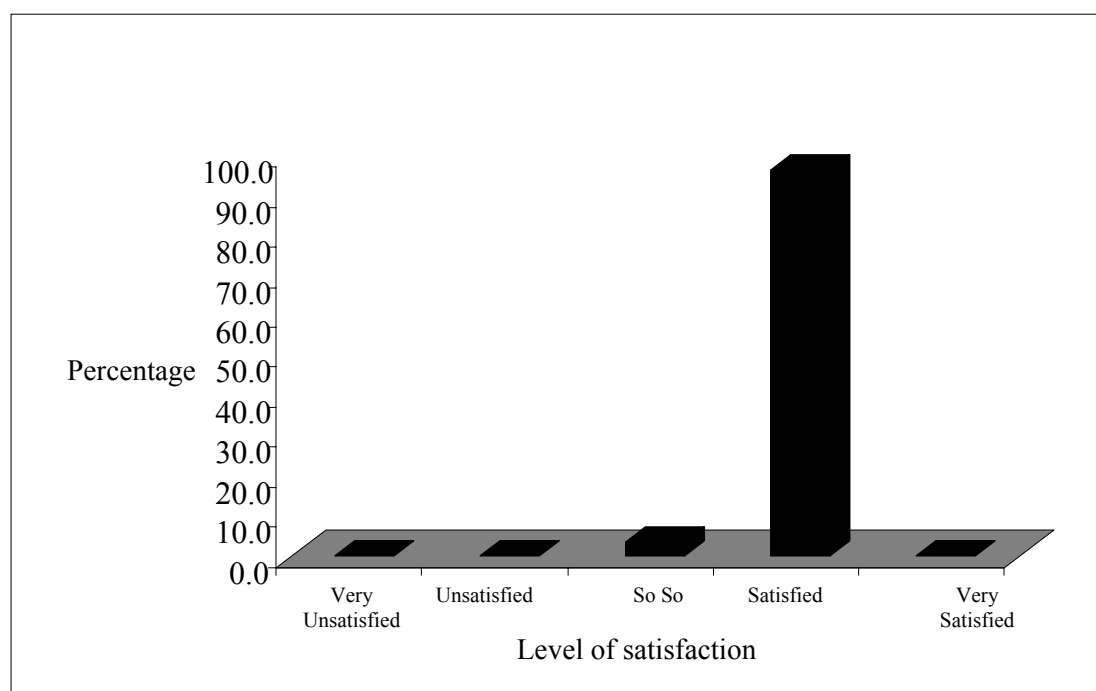
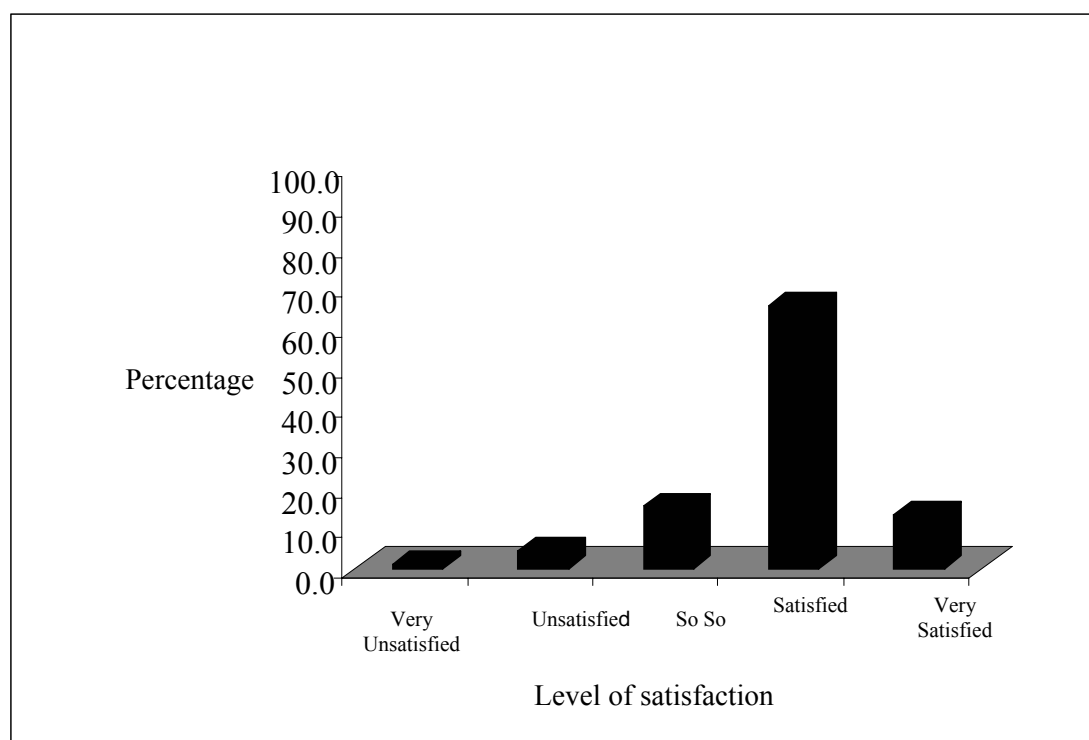


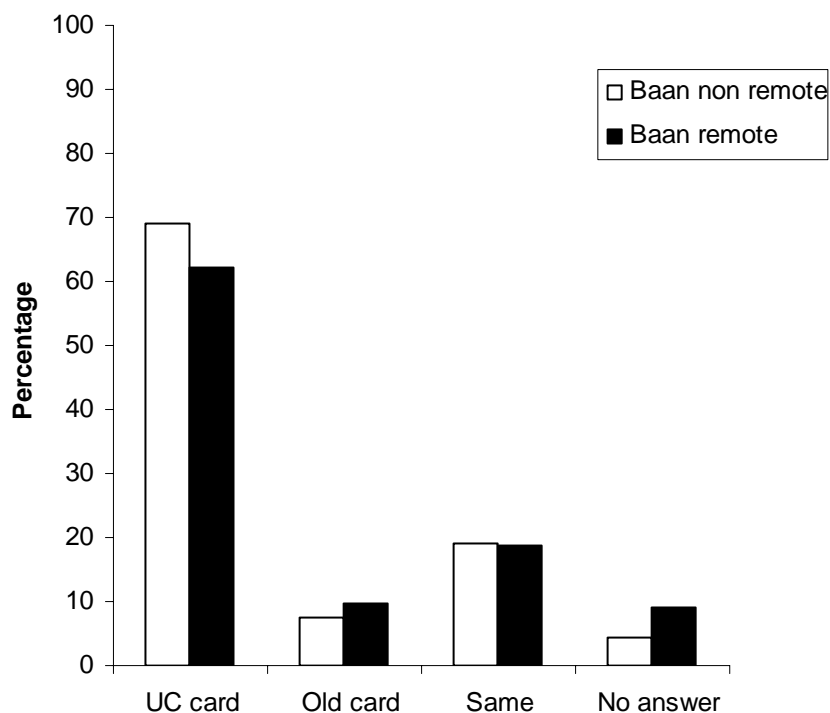
Chart 7.2 Distribution of total satisfaction on using UC card in remote village



The difference in satisfaction with using the UC card among villagers from the different groups (gender, class and age) was tested by using statistical analysis (see Chapter 4 for details). The analysis shows two significant results<sup>61</sup>. Firstly, women in both villages were more satisfied with healthcare services than men. Secondly, the poor in both villages were more satisfied than the other groups, although this result was significant only for the non-remote area.

Most importantly, villagers were more satisfied with the UC card than with other previous card schemes. That is, when the villagers were asked to compare the UC card with their previous card, it was found that more than 65 % of respondents in both sites reported that they were more satisfied with the UC card. Only 19 % of villagers were more satisfied with the previous card (Chart 7.3).

Chart 7.3 Percentage of villagers' satisfaction with the UC card as compared with the previous card



Source: Researcher's questionnaire surveys 2005

Chart 7.3 affirms the results from Table 7.1 that people in both villages were experiencing high levels of satisfaction with the UC card and this suggests that the

<sup>61</sup> All reported differences are significant at the level of 0.05.

scheme was having a significant degree of success. However, it was also found that 22.2 % of villagers (Table 7.1) felt that the UC scheme had some weaknesses and that some aspects required improvement.

Findings from the analysis of the questionnaire are supported by the results from the in-depth interviews (Table 7.2). Some villagers who used the card<sup>62</sup> were satisfied but some were dissatisfied with it, despite feeling that the UC scheme had caused more of their healthcare needs to be met and given them the ability to achieve their meaningful goals. Dissatisfaction with the UC card was reported more in the in-depth interviews. This supports the argument that questionnaire-based satisfaction studies alone are not adequate to reveal satisfaction among Thai villagers and the multi-method approach is more appropriate. Additionally, judging by the in-depth interviews it appears that the more that villagers used the UC card the less satisfied they were with it.

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<sup>62</sup> Not every interviewee who has the card has used the card, e.g. in the non-remote village three of the twelve have not used a UC card.

Table 7.2 Satisfaction and dissatisfaction in the non-remote village and remote village by age, gender and economic class

Age/ Gender	Satisfaction of UC card		Total
	Satisfied	Dissatisfied	
<b>Baan non-remote(N=12)</b>			
<b>Worse off</b>			
Young man	1		1
Young women	1		1
Middle age man	1		1
Middle age women	1	1	2
Old men	1	1	2
Old women	1	1	2
<b>Better off</b>			
Young man	1		1
Young women	1		1
Middle age man			
Middle age women			
Old men	1	1	2
Old women			
Total	9	4	13
<b>Baan remote( N=12)</b>			
<b>Worse off</b>			
Young man	1	1	2
Young women	1	1	2
Middle age man	1	1	2
Middle age women	1	1	2
Old men	1	1	2
Old women	1	1	2
<b>Better off</b>			
Young man	1	1	2
Young women	1	1	2
Middle age man	1		1
Middle age women	1	1	2
Old men	1	1	2
Old women	1	1	
Total	12	11	23

Source: In-depth interviews in the non-remote village (23 -27 November 2005) and remote village (16 -21 November 2005)

Note on age groups: Young =18-25, Middle age = 25-60 and Old = 61+

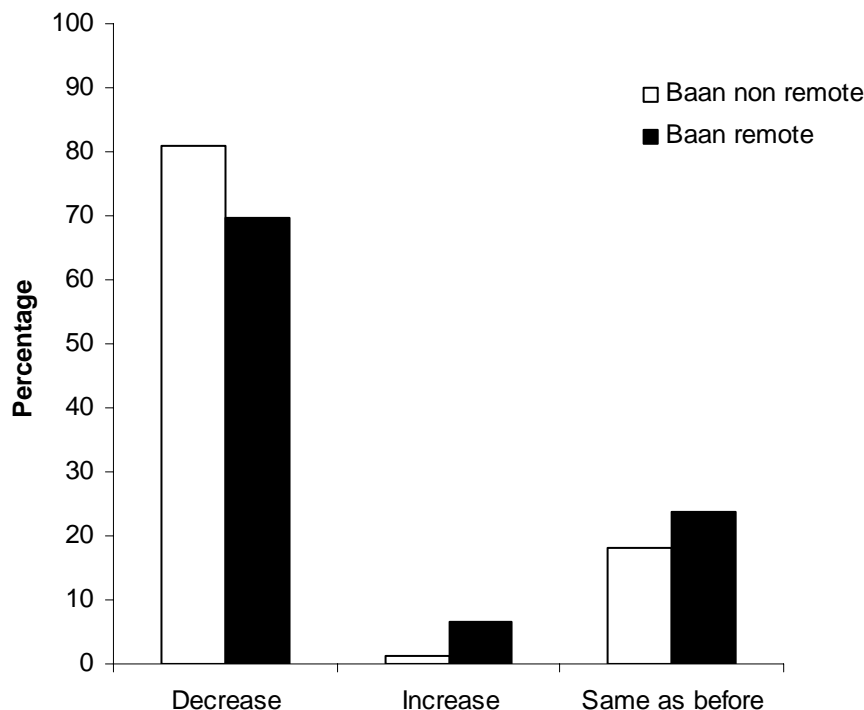
The reasons for being satisfied and dissatisfied with the scheme are explored in the following section.

#### 7.1.1.1 Reported reasons for being satisfied with the scheme

The three main reasons for villagers' satisfaction are as follows.

##### (1) Less cost

Chart 7.4 Villagers' perception of changes in household expenditure after the introduction of the UC card



Source: Researcher's questionnaires 2005

Chart 7.4 shows that a key explanatory factor for satisfaction is related to the financial benefits coming from villagers' decreased expenditure on healthcare. Most villagers in both villages reported that their household expenditure decreased after using the UC card (80.9% in *Baan* non-remote, 69.7% in *Baan* remote). This result is in line with the findings from other previous researches. For example, Tangcharoensatien (1996) and Jirojanakul *et al* (2004) who suggested that the main problem existing prior to the introduction of the scheme was limited access to healthcare caused by the inability to pay for expensive medical care. The smaller decrease in healthcare expenditure



observed in *Baan* remote could be explained by the fact that villagers in this area may still have to pay more for their travel to the healthcare centre than those people in the non-remote location.

When asked about how the UC scheme affected villagers' lives, many of them indicated that the UC helped them by relieving economic anxiety.

As one male focus group participant in the non-remote village said:

‘I think [the UC scheme] is a good one as I do not have to pay a lot. Whenever I am sick I know I can see a doctor, I don't need to pay much and I save more. It makes me less worried than before. In the past when I got sick I did not dare to see doctor as I was very afraid and I don't have money to pay’ (Male, 57 years old man 5 December 2004).

Another example was provided in the remote village focus group discussions. A health volunteer described a 78 year old man who compared the former-Prime minister with an angel, because the UC scheme saved his life. He was very sick and on the point of death but he refused to go to see a doctor as he had no money. However, many villagers told him several times that he would be cured for free by using the UC card, so finally, he made the decision to see a doctor and was cured. He later said: ‘*Thaksin Pen Devada Ma Prod*’ translated as ‘Thaksin is an angel who came to help the people’. However, a local health volunteer argued that this man had in fact been covered by a card scheme for older people and would have received free care even before the UC scheme was initiated. In this case, it appeared this man had not known that he had had the right to access free care before the UC scheme started, which suggests that the UC scheme had provided better information to villagers than the previous schemes and that villagers felt more comfortable about telling other villagers about the low cost or the free care that was available.

This is supported by the policy-maker who was interviewed during the fieldwork. One extreme but sensitive example, from a policy maker at the National Health Security Office (NHSO) in the Khon Kaen office, explained how villagers acted in the past when they had no money to pay to see the doctor.

‘I used to see people who allowed themselves to be sick, to die at home because they had no money to cure themselves. Some people had no money to pay for treatment at all and some had only money for transport. They feared that, if they used money to get better, their family would have nothing left, and some one would have to sell their cattle’ (A middle-aged women, 19 November 2004).

In light of this, this interviewee praised highly the introduction of the UC scheme as a means for alleviating poverty.

## **(2) More security**

With the perception that the UC scheme was affordable with low cost or free care, most of the villagers in both villages noted that the UC scheme made them feel more secure.

Data from the focus group discussions held with villagers in each site demonstrated similar perspectives, in that the UC scheme was considered as guaranteeing their mental security: it ensured that they had confidence to go to see a doctor and had fewer worries about their daily living expenses. The following examples support this point.

A woman from the non-remote village said:

‘Now it is better. Now even if I have less than 100 Baht I can still go to the doctor. I know that I pay only 30 Baht each time’. (Focus group 30 November 2004)

A similar feeling was expressed by a female from the remote village.

‘It is better than before. In the past we had to pay, didn’t we? It is very good if you have not much money.’ (Focus group 25 February 2005)

The above has demonstrated that villagers were more satisfied with the results of their using the UC scheme than with their previous experiences regarding other card schemes. Most villagers expressed their desire for the UC scheme to be continued (98.9% in *Baan* non-remote vs. 96.7% in *Baan* remote) and further improved. The

main reason for this was that they felt this scheme had contributed to their economic security which generated for them a feeling of ‘pleasure’ translated as ‘*Sabai Jai*’.

### **(3) Improvement of the health service**

There was some evidence that villagers felt better treated than before. Villagers had noticed some improvements in the health service provided to them under the UC scheme, such as health workers being better mannered and the provision of ‘complaints boxes’. Many villagers mentioned that, in the past, doctors and nurses had been rude to them on several occasions. Whilst the UC scheme was in operation, the government campaigned for patients’ rights (for example, people could sue doctors in cases of negligence or medical malpractice) through various media channels.

A woman from the remote village claimed that there were widely known reports of people suing healthcare institutions. She further said:

‘Now the doctor and nurse talk nicely. Before they were not good to villagers, sometimes I was yelled at. They are better because people complain. They behave better now. Before we did not know [about our rights]; now we know. Now they [the doctors] have improved, people complain. They are correct’ (Female, 62 years old 17 November 2005).

Another example of improvement was given by some villagers from the non-remote village. They were impressed with the service given by the hospital in terms of receiving extras, such as an ambulance service. In addition, it is noted that they had been provided with the opportunity to use a hospital that was previously not accessible to them. A female respondent stated:

‘before, this hospital was for the rich. If we didn’t have the 30 Baht [card] we wouldn’t have had any chance to come here’. (Female, 63 years old 18 January 2005).

As stated earlier, women respondents and the poor from the non-remote village appeared significantly more satisfied with the UC scheme. Firstly, it was possible that the women in any given household was the person taking care of the family’s health,

including looking after any sick family members; so they felt that they had a moral duty to take health precautions. This may have resulted in women's wellbeing being more connected to the household's wellbeing than that of men's. Moreover, women in the villages were usually responsible for family finances (Mee-Udon and Itarat, 2005; Blumberg and Mee-Udon 2002; Promphakping 2000), thus when the scheme benefited the family in terms of greater accessibility to health care at a lower cost, women may have felt that the UC scheme was helpful to them.

Secondly, whilst poor people in non-remote areas may have had more opportunities in terms of work, education and healthcare access, they also had higher costs of living than those who were living in a more remote area. They faced greater economic difficulties than people in the remote location so the fact that they knew that they could spend less on healthcare than before may have helped to explain their high level of satisfaction with the UC care.

From the villagers' point of view, the UC scheme was seen as very helpful in several ways. It was beneficial, in particular, to the poor, who were disadvantaged in regards to accessing healthcare because of their economic restrictions and it provided them the assurance that they could seek care when they needed it. This scheme created a greater sense of security for villagers, which could be considered to be a crucial human need (see Wood (2007) who proposed security as an indicator of human wellbeing). If villagers had not had access to this scheme, they would have had to spend a lot of money on healthcare but as they had been provided with a low cost or free service, they lived with less fear of threats to their health and wellbeing. This was especially true of women who were responsible for family healthcare matters and for the poor who had fewer resources to rely on in an emergency situation. Moreover, when the villagers could save money, they could potentially spend it on other things to further their personal wellbeing as well as that of their family members or they could even undertake merit deeds. Lastly, some villagers in both villages reported that their satisfaction had increased because they had been treated with more respect than before.

To sum up, this research reveals that the key explanations of people's satisfaction with the UC scheme are: 'lower costs', 'more security' and 'improvements in services'. Nonetheless, a considerable number of villagers from both villages remained

dissatisfied with the UC card (22.2 %) and their reasons are presented in the next section.

### **7.1.1.2 Reported reasons for being dissatisfied with the scheme**

The main reasons that were reported as leading to the villagers' dissatisfaction were as follows.

#### **(1) Restricted choices**

Owing to the UC scheme regulations, villagers on the scheme had to register with the government healthcare network, according to their residential location. This issue was raised as a serious complaint by some villagers in the non-remote village. They commented that they were forced to use the services at a hospital which they believed, following their previous experiences, was of a lower standard than another local hospital.

In the focus group discussions, some villagers in *Baan* non-remote recalled that they had experienced their hospital registration for the UC scheme being changed three times in the four years since the scheme was implemented. They believed that the quality of the hospital for which they were registered at that time was not as good as the previous one. Villagers said that they were forced to use this hospital by the UC policy administrators because the hospital was not making any money and needed more government assistance<sup>63</sup> (Focus group discussion, 8 December 2005). Some villagers observed that 'the hospital is collapsing; but it is still open because of the UC scheme.' In addition, villagers were not satisfied with the hospital service for other reasons including those of: 'young doctors' (presumably meaning inexperienced doctors) 'poor treatments', and 'false reports to the government'<sup>64</sup> (Researcher's field notes 2005).

Such criticisms illustrated problems experienced with the hospital services rather than with the UC scheme itself. However, these problems derived from the management of the UC scheme, because it was the service regulations that meant that the villagers

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<sup>63</sup> The UC scheme operated on 'capitation', so people were obliged to use the district hospital and primary care centre/s that formed part of their 'provider network' (in rural areas the provider networks were run by the MoPH). If they needed to use government facilities outside this network, for example, tertiary care, then they needed to obtain a referral.

<sup>64</sup> Data from the women's focus group noted that the hospital inflated the costs of care in its reports to the government.

could not choose their preferred place of service. Although they had found out which place provided good quality care, they had had to take the service as designated by their card. Otherwise, if they did not want to use the designated service they would have to pay for the one that they thought could provide a better quality of care.

In the case of the two men from the non-remote village who held two health cards at the same time, they thought that they had more choice. This was because the SSS beneficiaries could attend either private clinics or hospitals, while the UC beneficiaries only had access to the services mentioned on the card, namely in their residential area. In addition, these two men reported that they were treated with more respect when they used the SSS card.

## **(2) Poor quality of services**

Many villagers did not trust the quality of services received in terms of the medicine prescribed. In both villages many of the villagers did not want to go to the health centre, as they did not want to waste their working time, just to be prescribed ‘a typical pain killer, e.g. ‘paracetamol’ (Researcher’s field notes 2004 and 2005).

Table 7.3 Villagers’ opinions on the accessibility and quality of healthcare after using the UC card

Item	Non-remote Village		Remote Village	
	N	%	N	%
Level of healthcare (accessibility and quality) after using the UC card				
1. Decrease	4	4.3	14	11.5
2. Increase	7	7.4	33	27.0
3. Same as before	64	68.1	73	59.8
4. No answer/ don’t know	19	20.2	2	1.6
Total	94	100.00	122	100.00

Source: Researcher’s questionnaire surveys 2005

Table 7.3 illustrates the finding that the majority of villagers in both villages thought that the level of healthcare they received had not changed (68.1 % in *Baan* non-remote and 59.8 % in *Baan* remote). Many villagers explained that the card had encouraged more people to visit the healthcare services, which consequently had increased the number of patients thereby causing doctors to spend less time with individuals. Therefore they reported that the quality of the service received had gone down. Villagers in *Baan* non-remote apparently reacted to this reduction in service quality by switching to private healthcare because they believed it was worth paying money for their healthcare. As explained earlier in Chapter 5, more than 90% of villagers in *Baan* non-remote continued to pay for some or all of their healthcare.

The situation was different in *Baan* remote. Given that villagers had less opportunity to use other forms of healthcare provision as they lived in a remote area without many formal healthcare options, villagers might have formulated the view that their hospital and the health centre were ‘better than nothing’. Although they sometimes doubted the quality of the service, they still had to rely on it. This could explain the higher level of usage of the UC card as well as the more frequent criticism (the more people used the card, the more they complained), as mentioned in section 7.1 (see Table 7.2).

An example of the perception of the UC card as providing low quality service was given by a young man from the remote village, who originally had an SSS card and then changed to a UC card. He had had an accident and as a result became disabled. He described his experience of mistreatment under the UC card system and believed that his disability resulted from poor medical treatment under UC card:

‘When I had a motorcycle accident, I broke my leg. At that time I was on the SSS (social security scheme). After that, I lost my job and I had to use the 30 Baht scheme. When I was on the SSS, I was treated much better and quicker; I was even referred to a hospital in Bangkok. But, when using the 30 Baht scheme, the same (name-undisclosed) hospital used a cheap replacement material for my leg. I think it made me unable to walk properly to this day. It has been two years’. (Male, 21 years old 21 November 2005)

From this respondent’s perspective, the SSS card and the UC were very different. For example, according to his story, a friend also underwent the same operation but his friend had held a SSS card so apparently he had been given a better quality pin in his

leg. However, the respondent had to undergo a second operation because the original pin failed. The respondent believed he would have only had one operation if the first pin had been of higher quality.

These two examples underline the villagers' belief that the UC scheme supplied healthcare 'on the cheap' for the poor and therefore did not provide a good quality of service. On the other hand, the SSS, which offered a better quality of service, was considered as provided for the middle class and the rich. Maybe this explained why some villagers preferred to pay for a better service, even though they were poor and struggled to afford it.

From my observations of living in *Baan* remote and through going to the health centre on several occasions with villagers, it was noted that the health centre was rarely fully staffed; for example, on one visit a sign was posted up that read 'all doctors have departed for a meeting in the city'. From such evidence, it became clear that the villagers in *Baan* remote were faced with ineffective provision of state-run healthcare services. However, the villagers did not respond to this passively but found other options for healthcare and treatment; for example, they still used their own medicines from herbs and their medical knowledge learned when living in the forest as they felt able to access and control these resources when needed. There were several 'village doctors' (that villagers could visit, including at least six 'doctors' who were experts in administering acupuncture, traditional reproductive care, glucose drip and spiritual and magical treatments (Researcher's field notes 2004 and 2005).

### **(3) Discriminatory treatment**

In both villages, there were some indications of unequal treatment for villagers who originated from different economic and social classes, for example, more favourable treatment of people who were perceived as educated. One young man from the non-remote village described how using the UC could exacerbate people's feelings of poverty:

'My relative went to hospital for her baby to be delivered. She used a gold card [i.e. UC card], and she had to stay in an open ward, no privacy. People who used the gold card have to stay in multi-bedded rooms, with no curtains and no



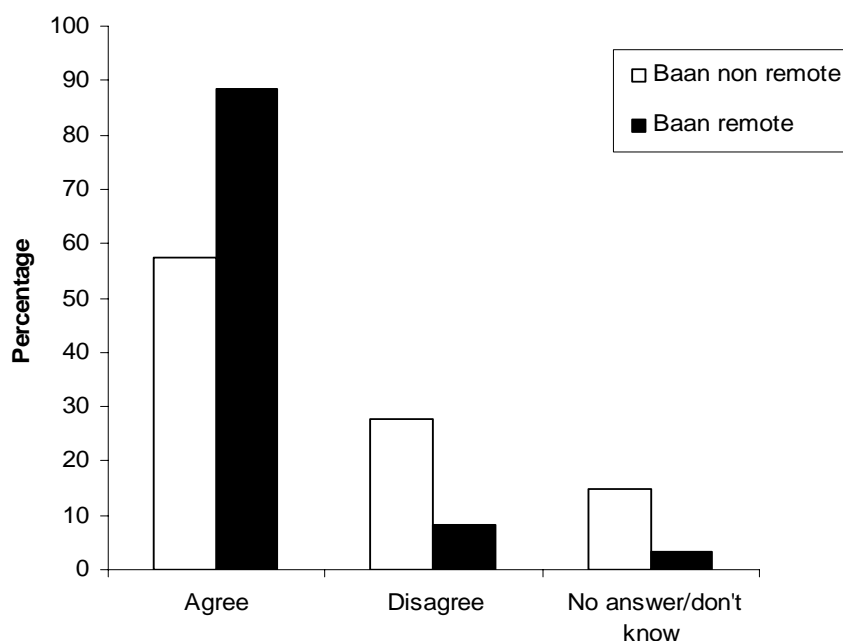
privacy. If we have money we can pay for a better service and they will treat us better. But what can you expect if you are poor?’  
(Male, 25 years old 27 November 2005).

Discrimination was a more important concern for villagers in the remote area as their choice of formal healthcare was limited. An example may be seen in the narrative given by a girl from the remote village who described her own experience of using the UC card.

‘I saw a doctor telling a woman off. But myself, I wore a student uniform and so the doctor did not say any impolite words to me. I felt sympathy towards her as she was a common person. If she were a civil servant, I am sure she would be treated better’ (Female 18 years old, 19 November 2005).

There was also a notable difference in villagers’ opinions with regards to whether the UC should be a universal service throughout Thailand, thus ensuring that all Thais received the same rights and standard of treatment. This is illustrated in Chart 7. 5.

Chart 7.5 Percentage of villagers who agreed that all Thai citizens should use the UC card



Source: Researcher’s questionnaire surveys 2005

Chart 7.5 demonstrates that more villagers in *Baan* remote (88.5%) than *Baan* non-remote (57.4%) believed that the UC card should be used by all Thai citizens. The reason for the inhabitants being more in favour of greater equality in healthcare provision, could be related to their communist history and hence their sense of fairness (see Chapter 5 for the research sites background). Although the data reported on in section 7.1.1.1 (3) suggested that some villagers were treated with more respect than before the introduction of the UC scheme, some villagers reported that they received poorer healthcare and were treated with less respect than rich patients. This was most acutely felt when some respondents compared the UC scheme with other schemes that they knew about, such as the Social Security Scheme (SSS) or the Civil Servants Medical Benefit Scheme (CSMBS). These findings suggest that there were several problems with the implementation of the UC scheme such as: ‘restricted choice’, ‘poor quality of service’ and ‘discriminatory treatment’. These issues apparently prevented some villagers from benefiting from the UC scheme and potentially may have prompted them not to use it in the future.

This section has highlighted the numerous factors which influenced villagers’ satisfaction and dissatisfaction with the UC scheme. According to Gough and McGregor (2007), satisfaction can be considered to form an essential part of the experience of wellbeing, moreover, the next section explains in what ways satisfaction with the UC scheme contributed to villagers’ life satisfaction.

### **7.1.2 The extent of the contribution of the UC scheme to villagers’ life satisfaction**

The villagers’ satisfaction with the UC scheme in terms of its ‘lower cost’, ‘more security’ and ‘improvements in services’ to a certain level affect their satisfaction with their life as a whole. It may be argued that this assumption is too simplistic as the villagers’ life satisfaction cannot be considered separately from other related factors such as: their living conditions, family, community, surroundings, political environment, and their individual personality and outlook on life. However, as we have seen in the previous Chapter 6, health is one of the factors considered crucial in the villagers’ lives. This research has indicated that access to appropriate healthcare in the form of the UC scheme has made a contribution by meeting their healthcare needs and enabling them to act more meaningfully.

In order to explore the effect of the UC scheme on life satisfaction, it is necessary to discuss this in relation to each of the two groups of UC scheme user: user and non user. Firstly, the discussion will address the user who is satisfied, followed by the user who is dissatisfied. Secondly the non user group is considered.

### **7.1.2.1 UC card usage group**

The findings in the previous section showed that the majority of villagers who used the card were satisfied with the results of their using it. How this affected villagers' life satisfaction needed to be clarified, and there are questions regarding what made up the villagers' life satisfaction and how was this to be investigated in this study. To respond to this, this thesis employed one of the most widely used questions on quality of life and satisfaction which was taken from the PGI<sup>65</sup> (see Ruta *et al* 1994). The relevant probe taken from the survey was as follows: 'What are the five most important things that affect your quality of life?'

When this question was deployed the responses showed that despite their different location the findings from the two villages were similar in that in both places they considered that money was the most important factor that affected their quality of life (Table 7.4). Other important factors were found to differ according to the site, for example, in *Baan* non-remote health was the second choice, followed by rice/food, a happy family and lastly a good job. In comparison, in *Baan* remote land was more important than a good house, health and a car, because as explained in Chapter 5, they did not own the land and aspired to do so. Moreover, the long distances from the towns and cities meant that in this village owning a car was given higher priority than in *Baan* non-remote. The results from *Baan* remote are due to the fact that villagers there do not have rights over their land and suffer from lack of transport (see Chapter 5).

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<sup>65</sup> See details in Chapter 4.

Table 7.4 The five most important things that affect villagers' quality of life  
(PGI- Personal Generated Index of Quality of life)

<i>Baan non-remote</i>	<i>Baan remote</i>
1.Money	1.Money
2.Health	2.Land
3.Rice/ Food	3.House
4.Happy family	4.Health
5.Good job	5.Car

Source: Researcher's questionnaire surveys 2005

The importance attributed to 'having good health' is validated by the results in table 7.4 which shows that although in the aggregated responses for both villages money was the most important, health also rated highly, being second and fourth in *Baan non-remote* and *Baan remote*, respectively. With money being ranked first, this would imply that having the UC scheme with its accompanying financial benefits (see section 7.1.1.1 (1) in this chapter) would have improved the villagers' incomes and hence contributed to their level of satisfaction and their quality of life.

Satisfaction with the UC scheme can be transferred to satisfaction with other aspects of villagers' lives at two levels. One is the 'objective' dimension and the other the 'subjective' dimension. The objective dimension can be explained by considering two main factors, lowering cost and having options. In addition to lowering cost, which was considered a key factor, it was found that the UC scheme also provided wider options to villagers in terms of access to healthcare. This enabled villagers to act more meaningfully in regards to access to healthcare. When villagers had options it could be expected that they were more empowered as regards choice; the UC scheme had enhanced their capabilities and therefore their life satisfaction level (Sen 1999).

Another important finding from the survey was the increased level of satisfaction amongst villagers in both locations regarding the UC card when compared with previous cards (see above in Chart 7.1). This finding was affirmed by the data from the

focus groups in both villages and a consensus emerged amongst villagers that they were more satisfied with the UC card than with their previous cards (Focus groups: 30 November 2004, 5 December 2004 and 25 February 2005). The prime reason given for this was that it was appropriate to their needs as it was low cost. Most villagers used the word '*Roo Suek Dee Khuen*' or 'feeling better' to express their increased satisfaction with it.

In terms of the subjective dimension, it was observed that the UC scheme enhanced villagers' security as regards feeling safe from economic and emotional anxiety. When the villagers knew that the UC scheme could help them to save on potential medical expenses they felt confident to go to see a doctor as they realised that they could act meaningfully. That is to say they possessed the ability to control their medical expenses (although not travel expenses), food, and other related costs, which could help them avoid financial difficulties at an individual or family level. In addition the scheme represented a form of government-based health insurance, which helped villagers' lives attain a greater degree of security and made the villagers feel better served by social policies. The effects of the UC scheme on villagers' life satisfaction can be discussed by referring to the THN (Doyal and Gough, 1991) in which economic security represented one element of fulfilling the basic need of security as discussed in Chapter 3.

Another explanation for villagers' satisfaction with the UC scheme and to life satisfaction as a whole may be linked to the influence of the Buddhist religion, as followed by the villagers in the research sites. A religious male respondent referred to a teaching of Buddha in which he learned how to overcome the sense of dissatisfaction. He said in Pali '*Nutti Tanhah Sma Natee*' which in Thai means 'no river is equivalent to the river of desire'. This phrase can be explained as; people's desires are much wider than rivers and they are limitless. (Researcher field note 2004). According to this phrase, if one has desire, the more it is, the more '*Dukkha*' or dissatisfaction one feels. One has to recognise this and control one's desire because it is the cause of the dissatisfaction in life. Many villagers had expressed their opinion that one should be contented with '*Patjai Sii*' which means the four conditions/necessities of life which are clothing, food, dwelling and medicine.

The villagers' way of life and 'the modest self-presentation' (Gray *et al* 2008) are influenced by Buddhism through which they are taught to be '*Por Jai*' or 'being satisfied with what one has', as some scholars have highlighted (Phra Debpvatdi 1994, Pra Dhammapidoka 1996). Additionally, many villagers accept King Bhumibol's idea on 'sufficient economic, sufficient living' as one of their living guidelines. These findings are supported by Cummins (2008) and Gray *et al* (2008) who suggested that optimistic responses from Thais are part of the national culture in which they were brought up. Expressing gratitude is another Buddhist teaching: when villagers found that the UC had contributed to their wellbeing, at both personal and family levels, they were satisfied with the government's policy and expressed their gratitude through '*Pen Nii Boon Koon*' or to be under an obligation, by re-electing or repayment the government, as discussed in Chapter 5.

In addition, as explained in Chapter 4, '*Kreng Jai*' or 'to be afraid of offending someone, to be considerate of another's feeling' is considered to be a characteristic of Thai people. This could help explain the fairly high satisfaction with the UC scheme and their lives expressed by some of the villagers, as previous expectation levels started from a low base. From living with villagers it was found that they were too '*Kreng Jai*' to complain about their dissatisfaction with the UC scheme and with their lives. In many societies complaints about injustice and unfairness are common, however; in Thailand the act of making these complaints would be considered by many rural people as one that reduces the quality of life. Moreover, many of the villagers expressed the belief that those who complain have fortunate lives and sometimes overlook the privileges and benefits that they have (Researcher's field note 2005).

A considerable number of villagers who used the UC card were dissatisfied with it when they were interviewed. They suggested that the UC scheme needed to be improved, for example, regarding the quality of services in terms of the medicine itself and the quality of care given by medical staff. Moreover the scheme provided more limited options than other existing governmental healthcare systems. However, even though they expressed their negative opinion to the researcher regarding the scheme, very few of those interviewed had complained.

As mentioned in Chapter 6, although the UC scheme has provided more of villagers' healthcare needs and enabled them to act meaningfully to achieve their meaningful

goals, some of them were concerned about the quality on offer. However, it was found that most villagers were satisfied with the UC scheme. There two possible explanations for this:

First, the UC scheme has truly increased the security among villagers and the increased security they feel is more important than their concerns about its quality.

Second, the relatively high rate of satisfaction reported with the service in the questionnaires may not reflect the actual quality of the service due to the cultural value of '*KrengJai*' and '*Por Jai*' described above. This makes villagers more reluctant to express their feeling of dissatisfaction.

These examples illustrate the benefits of triangulation using a multi-method approach.

#### **7.1.2.2 UC card non usage group**

This section moves on to examine those villagers who did not use the card and the issue of life satisfaction for them. Those villagers who held the UC card but had never used it presented various reasons for not using it: minor sicknesses, the issue of opportunity cost, alternative choices, perceptions that the healthcare on offer was of lower quality and the influence of culture.

For example, this researcher interviewed a young man who held two cards, both the UC and the SSS, but he had never used the UC card. However, he regarded the UC scheme as metaphorically like having food in reserve. He said,

‘Having a gold card is like having rice. It is better to know that at least we have rice to eat, better than no rice<sup>66</sup> at all.’ (Male, 25 years old 24 November 2005)

This example suggests that although he had not obtained direct benefits from using the UC card, he had still been receiving indirect benefits from having access to the card. Similarly, the other non users expressed the view that having the UC card made them feel more secure as it acted it as a security blanket, in terms of being a spare resource

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<sup>66</sup> Thais perceive rice as a staple of everyday life. When people want to ask ‘Have you eaten yet?’ they say ‘Have you eaten rice yet?’

they could draw upon in times of need. That is, this sense of having health insurance increased these villagers' economic security and gave them peace of mind which enhanced their ability to act meaningfully ( see Sen 1999 and Gough and McGregor 2007). Furthermore, according to the THN ( Doyal and Gough 1991) this healthy state of mind for villagers facilitates more participation in the social or relational dimensions of life.

## **7.2 Meaningful actions**

In order to understand the significance of villagers' satisfaction, it is necessary to investigate some of the contributing ideas to this satisfaction by exploring the way in which people explain reason for their meaningful actions.

### **7.2.1. *Reasons for card usage***

#### **7.2.1.1 Cost saving purposes**

Saving on medical expenses is an underlying reason for most villagers who act to use the UC card, regardless of location, gender, age or economic class. The following statements are examples of this:

Non-remote villagers

'In the past, the card didn't exist. I had to pay a lot.'

(A better off female, 18 years old, 26 November 2005)

'We don't have to pay ourselves. They charge the government for the fees'

(A worse off male 56 years old, 27 November 2005)

'The gold cards are useful. There's no need to pay.'

(A better off male 64 years old, 27 November 2005)

Remote villagers

'Elsewhere the prices of medicine and hospital fees are high.'

(A better off male 55 years old, 17 November 2005)



‘If we use the gold card, we don’t have to pay.’

(A worse off male 55 years old, 16 November 2005)

‘The scheme helps us to save’

(A worse off female 22 years old, 17 November 2005)

More importantly, using the UC card is very helpful for those who cannot afford to pay large medical expenses. As shown in previous Chapter (Table 6.10), the poor in both villages had a greater percentage of card usage than those in other economic classes. Findings from the in-depth interviews confirmed that the UC scheme was essential for the poor, not only in terms of providing an affordable healthcare service, but also in terms of their quality of life and living standards. The following excerpts are taken from interviews with poor people in both locations.

A villager from *Baan* non-remote commented that:

‘Rich people usually get medical care from clinics as it’s more convenient. But poor people need to wait for the government’s help because they don’t have the money. If the illness is not too serious, they buy medicine or just go to a local health centre to save money rather than travelling to a hospital. It’s more convenient (Female 59 years old 23 November 2005).

Another poor villager from *Baan* remote claimed that it would be impossible for him to survive without the UC scheme, given that he has a chronic illness and has a low income. It is essential for him to obtain medicine monthly which is provided free of charge under the UC scheme.

‘I go to a doctor every month because I’ve got asthma. I need to get medicine and inhalers. Without the free medicine from this scheme, oh! I don’t think I will survive. In the past I used to rely on a lower income card, which was also free. So both cards are equally good as there’s no need to pay at all (Male 55 years old 16 November 2005).

### 7.2.1.2 Being female

Data from women and men's focus groups in both villages illustrated that women are generally perceived as being relatively weaker and thus requiring more frequent visits to doctors. The main reason for this, according to some villagers, was that their reproductive role makes them weaker and thus women tended to see doctors more often, and therefore had more occasions to use the UC card. These observations confirm earlier findings presented in the Chapter 6 regarding the higher percentage of women in both villages using the UC card. Some illnesses that were thought to be caused by female physiology included those concerning *mot luuk* (womb or uterus), as seen in the example below taken from an in-depth interview with a middle-aged woman:

‘After I had children I did not ‘*yuu fai*’<sup>67</sup>, and it made me have ‘*mot luuk*’ problems<sup>68</sup>. Now I have diabetes and I feel my husband does not want [to have sex with] me’ (Female, 58 year old, 11 February 2005).

Most women who the researcher interviewed said that ‘men are lucky’ as they do not have to experience ‘women’s problems’. Both young and old women agreed that women’s illnesses result from the fact that they undergo pregnancies and deliver children thus the womb is the source of health problems. Many young women experienced period pains, but those who were married might experience different problems, mainly due to infections of the womb. One woman interviewed had eight children, as she would not undergo sterilisation, because her mother-in-law had told that her those women who had this ended up dying as a result.

Another reason that explains the higher rate of the UC card usage amongst women, particularly in *Baan* non-remote, could be related to the workplace environment of women. A large number of them were fishing net workers who earned a very small amount of money owing to the time taken to finish making a net, as described in

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<sup>67</sup> ‘*Yuu Fai*’ is a tradition practised by women after having childbirth ( see Chapter 5) Most women in Baan remote still practise this tradition while most women in Baan non-remote do not, possibly due to the time it takes (Researcher field note, 2005)

<sup>68</sup> See Gray and Punpuing (1999) Boonmongkon et al (2001) and Whittaker (2000) for a description of these ‘syndromes’ in Northeast Thailand. These researchers offer a rich explanation of the cultural issues that influence health and gender in Thailand.

Chapter 5. This work was reported to have negative effects on women's health as they had to sit and concentrate for long periods at a time, which may have resulted in sickness. This point is discussed in greater depth below.

For women in *Baan non-remote* even if they work all day, they may earn only about 30 Baht (1 pound is approximately 60 Baht). Thus, for women who had the co-payment card (where the patient pays 30 Baht for each visit) seeing a doctor meant that they needed to work and earn the equivalent of one day's wages. Although villagers may not have spent much time travelling to hospital, waiting for treatment may take all day, which would mean a further loss of income. A great number of them had had health problems related to eyestrain and problems in their shoulders and knee joints caused by their seated working position which they had to sustain for long hours. To combat this they sometimes helped each other by using traditional massage, but for more serious pains, most women could take painkillers, which they could buy from stores in their village. Moreover, medical records show that the main reasons for women seeing doctors in *Baan non-remote* were to receive physiotherapy.

Figure 7.1 Village women performing traditional massage to treat back pain.



Source: The researcher's own picture

Women in *Baan* remote, owing to the distance from the local healthcare centre, had more difficulties than women in *Baan* non-remote in using the UC card. In addition, lack of confidence in riding a motorcycle was a factor that limited many of the women's mobility. In interviews, some women said that the only reason why they could not go to the local healthcare centre was because they could not ride a motorcycle; thus it was inconvenient to travel there (Researcher's field notes 2005). This data suggests that, even though women may have a UC card, possession of the card alone could not enable them to meet their healthcare needs in remote rural areas.

In sum, it was found that for women, the main reasons for seeing a doctor were not only related to ill health, but to receive the contraceptive pill as described in Chapter 5. Results from the questionnaire found that in both locations women were solely responsible for family planning matters.

### **7.2.1.3 Severe illness and preventive purposes**

The UC card was employed when villagers were ill and their illnesses were considered 'serious'<sup>69</sup>. In the event that villagers were unable to treat their illnesses themselves, the villagers needed to see a doctor and may have had occasion to use the card. When villagers had a chronic illness such as diabetes and high blood pressure, they were advised to see their doctor for a regular health check and most of them used the UC card for this and for their medication. However, this does not necessarily mean that the UC cards are utilised for all severe and chronic illness cases. In other words, using the cards represents only one of the available options for villagers. As stated earlier, this research also found that location, gender and economic class proved to be factors that determined usage of the card.

Most villagers used the UC card in order to have access to necessities such as children's immunisations and contraception. It was found that villagers from both locations have relatively good access to basic healthcare services in terms of vaccination and contraception (Table 7.5).

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<sup>69</sup> Serious illness refers to conditions that resulted in villagers being unable to work (Researcher's Field note 2004).

Table 7.5 Percentage of households that have received contraceptives and/or condoms and the vaccination in Thailand of children under the age of 5 in 2004

Items	<i>Baan non remote</i>		<i>Baan Remote</i>	
	N	%	N	%
Children under 5 years old that were vaccinated (% of total population that are under 5 years old)	51	91.1	83	95.4
Households that have received contraceptives and/or condoms (% of total households)	20	12.7	99	50.5

Source: Adapted from WeD RANQ (2005)

Table 7.5 shows that more than 90% of children under the age of five in both villages were given vaccinations (91.1% for *Baan non-remote* vs. 95.4 % for *Baan remote*) (RANQ 2005). However, it is found that the statistics for receiving contraception are not as high as for vaccinations (12.7% for *Baan non remote* vs. 50.5 % for *Baan remote*) (RANQ, 2005). This data demonstrates a higher percentage of villagers in *Baan remote* received all types of vaccination for children and all types of contraception, when compared with *Baan non-remote*, which is surprising as many people in this area, as described in Chapter 5, are reliant upon their own medical care.

There are several reasons that could explain this high level of this phenomenon. The first explanation is that many villagers who used traditional healthcare are not children. Secondly, in both areas, vaccination is considered to be necessary for villagers' children. Thirdly, the villagers in *Baan remote* may have been targeted by highly effective government schemes to promote family planning and vaccination. Fourthly, both items are essential, but they cannot be provided by the village's own medical resources. The last explanation for the low percentage of contraception in *Baan non remote* is probably due to the greater availability of contraception in which means that villagers can buy them from pharmacies nearby. As a consequence, the remote villagers had to obtain these modern medical treatments through the UC card system and with free of charge.

Figure 7.2 The most common reason for women visiting the hospital is to obtain contraceptive pills.



Source: The researcher's own picture

These results confirm that usage of the card is not limited to times when people are unwell, but that it is also relied on to prevent illness. In fact, it was perceived as a source of support by villagers both in normal circumstances and in the case of illness. However, this research also found that the initial campaign, '30 Baht treats all diseases', had led many villagers to believe that this scheme served them only when ill. In order to amend this widespread misunderstanding, the campaign slogan has been modified by the government in 2005 to the phrase '30 Baht helps the Thais be free from disease', but the new slogan is not as well known as the original one.

In order to identify which source villagers chose for their health treatment and in what circumstances they selected to use the UC card, the questionnaire asked about health-seeking behaviour when sick. It was found that although most villagers reported themselves as being sick in 2003 (88.3% in *Baan* non-remote and 73.8% in *Baan* remote), most of them did not use the UC card (75.9 % in *Baan* non-remote and 53.3 % in *Baan* remote). The following section offers reasons why villagers did not use the UC card even they could have done so.

## 7.2.2 Reasons for card non usage

### 7.2.2.1 Trivial illness

Table 7.5 illustrates that more than 50 % of villagers did not use the UC card because they regarded their illnesses as minor <sup>70</sup>(50.0 % in non-remote village, 59.4 % in remote village). Data from the questionnaire regarding illnesses that villagers in both sites had experienced in the last year, showed that most common problem was that villagers had had was a cold and the second most common problem was muscle pain. These conditions were considered minor. Most villagers believed that these illnesses were not worth bothering the doctor with or not serious enough to seek treatment of any kind and could be self treated, which may explain the lack of use of the UC card.

Table 7.6 Reasons for not using the UC card

Reasons for not using the UC card	Baan non-remote		Baan remote	
	N	%	N	%
1. Minor levels of sickness	17	50.0	19	59.4
2. Do not want to wait for a long time/ no time	4	11.8	0	0
3. Seeing doctor at local clinic	4	11.8	2	3.3
4. Buying medicines at local store	4	11.8	2	6.3
5. Unsure of the quality of the healthcare offered	4	11.8	0	0
6. Using herbs or traditional treatment	0	0	3	9.4
7. Moving to other province	0	0	3	9.4
8. Using other card	0	0	2	6.3
9. Other reasons	1	2.9	1	3.1
Total	35	100.0	32	100.0

Source: Researcher's questionnaire surveys 2005

<sup>70</sup> This refers to illnesses that the villagers considered to be curable through self-treatment methods. These methods ranged from no action to simple self treatments such as resting, eating nutritious food, taking herbal medicines or purchasing medicines (Researcher's field note 2005).

As is shown in table 7.6, fundamental differences in the attitudes of people in the two villages lie behind reasons for non-card usage. For example, in *Baan* non-remote the reasons included: time constraints (11.8%), buying medicine (11.8%), seeing a doctor at a local clinic (11.8%), and being unsure of the quality of the healthcare offered (11.8%), whereas the reasons given in *Baan* remote were: ‘illness can be treated by herbs or using traditional treatment’, and ‘moving to another province’, in which case the migrant might have had to use private services as he/she could not easily transfer the UC registration. An interesting point from this table is that while considerable attention has been given to the issues of time and service quality in *Baan* non-remote, this becomes less of an issue in the *Baan* remote. Furthermore, migration and use of traditional medicine are issues specific to *Baan* remote.

### 7.2.2.2 Opportunity Costs

Using the UC card was considered to be a very time consuming process. As reported in Table 7.5, the issue of time was more of a concern for respondents in the non-remote than remote village, but in-depth interviews showed that villagers from both locations tended to ignore their own ill health owing to time constraints. An interviewee from the remote village described how he did not go to hospital because he could not afford the travelling costs; it emerged in a further conversation that the underlying reason was to avoid wasting his working time.

‘Nowadays I’ve got a job transporting potatoes in a farm. If I didn’t go to work, income would be lost, about a hundred Baht each day. Sometimes when I’m ill I still need to work. If it’s not too bad, it will just go away by itself. If it doesn’t get better, I’d get some medicine [from shop nearby]. Sometimes we share it among friends.’ (Male 20 years old 16 November 2005).

Using the UC card led to delays in receiving help and hence some villagers could not afford to wait for treatment and preferred self-prescribed drugs. The issue of self-prescribed drugs was one of the main concerns before the implementation of the UC (Tangcharoensathien 1996). However, even after the UC scheme, this problem still remains. One possible reason to explain the high levels of use of unsafe drugs among Thais is the issue of ‘lack of time and money’ Camfield (2006). Most respondents



agreed that the best health seeking strategy is one that is ‘quick and effective, even if it costs more’ (Camfield (2006:22). This issue can be explained by the theory of opportunity cost (Buchanan 1969). In this context, the poor person is reluctant to see a doctor and to use the card because they recognise that it consumes their working time or leisure time. As mentioned earlier, using the UC card is seen by many villagers as ‘not worth it’ because they receive only common medicine such as paracetamol and thus they prefer to pay in order to achieve a better result.

Another example from the researcher’s observations is taken from an occasion when the researcher went to hospital with a woman in the non-remote village as she was experiencing pain in her shoulders. In total, we spent around half a day in doing this, owing to the long queue and the complexity of the service. Although she had a free card and paid only 16 Baht (27 pence approximately) for the transport, she was very worried about her waste of time and as soon as she returned from the hospital, she started work immediately. When I asked her why she did not allow herself any recovery time she explained:

‘If I don’t work, I have nothing to eat... I have to work because I am very poor. Poor people don’t have much choice but to work until they die.’ (Female 56 years old 18 January 2005).

The issue of time and ‘opportunity cost’ appeared to be a particularly significant factor with regards to card utilisation for the non-remote villagers. This was confirmed by examples which explained the reason for not using the card given by some older people in *Baan* non-remote.

As mentioned in Chapter 2, in Thai society people are brought up to treat the elderly with great respect. Although family members are often willing to help the elderly, particularly when they require medical care, they practise ‘*Kreng jai* <sup>71</sup>’ (see Chapter 4 page 155) and thus are often reluctant to ask for favours, so as to avoid creating trouble for their family. The following example was given by an interviewee:

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<sup>71</sup> This word was referred to in Chapter 4 and is translated into English as ‘to be afraid of offending someone, to be considerate of another’s feeling.

‘When I’m ill I don’t want to disturb my family. They’ve got work to do. Sometimes I go to hospitals myself by public transport. It’s not possible not to go because it’s necessary. Even when I’m tired I still have to go’.  
(Male, 84 years old 23 November 2005).

A similar reason was given by another informant from the same village. She said that she would go to the clinic even if the illness was not serious, avoid disturbing the other members of her family (Female, 61 years old 23 November 2005). From interviews, it was clear that in the non-remote area, older people were more aware of the economic value of time than in the remote village. In many cases, it may be that the non-remote elderly may choose to go to clinics and pay fees, or buy medicines at local pharmacies, rather than waste their family members’ valuable time.

The above examples illustrate that villagers’ concern was centred on the waste of time rather than their other priorities. Moreover, from these interviews, it appeared that the problem of time was considered more serious by the poor villagers in both villages. This finding is supported by the work of Chambers (1989) who wrote: ‘The main asset of most poor people is their bodies’ (cited in Kabeer 1999:146). It also is confirmed by Camfield (2008) who titled her paper on health in Thailand ‘Spending health to earn money’.

Figure 7.3 An old woman is working at her home in order to survive.



Source: The WeD-KKU's picture

The findings here show that although most villagers considered good health to be more important than wealth, a gap has appeared between the villagers' health goal (ie. having good health) and their meaningful action (ie. having to work for their own wellbeing or the wellbeing of family members). This is because, in reality, most poor people worry more about shortage of money or the time taken to earn it, than their health.

### 7.2.2.3 Having more choice

#### Having alternative healthcare facilities available

Some of the study findings indicate that the availability of alternative healthcare facilities have had a significant impact upon the amount of card usage in both villages. Although in the *Baan* non-remote location it may have been more convenient to use the UC card than in *Baan* remote, a higher percentage of card usage was found in the latter.

A villager from *Baan* non-remote explained in the focus group that:

‘I would always avoid hospital [A] even when I'm seriously ill because I don't want to die (laugh). There aren't enough doctors, just four people. Most of them are still very young. Previously, this village is covered by hospital [B] but we had to move to hospital A because of the 30 Baht project. If I've got the money, I just go to clinics as it's more convenient. If it's very serious, I just go to hospital B, although I've got to pay.’ (Focus group 30 November 04)

A contrasting explanation was provided by an informant from *Baan* remote, albeit with regards to a different hospital.

‘This scheme is quite good for people that don't have money. The services provided by hospital [C] are so-so, sometimes good, other times not, but we still need to go there. In the past, we never went to the doctors because there were no roads. We just relied on herbal medicines. But nowadays there are modern illnesses that come with food from the markets, from Monosodium Glutamate [MSG, a common food additive]. Therefore, we need to see doctors.’ (Focus group 25 February 05)

The above examples demonstrate that non-remote villagers had various alternatives for accessing healthcare. These choices may have had the impact of lowering the percentage of UC card usage observed here, which contrasted with *Baan* remote where the UC was seen as one of the villagers' available options.

This point is supported by the data regarding healthcare spending, in that in this research it emerged that, in 2005, 92.6% of villagers in *Baan* non-remote paid for healthcare, compared to only 31.14% in *Baan* remote. Villagers in *Baan* non-remote spent almost triple that of residents of *Baan* remote on medical services.

#### Having the ability to pay

As explained earlier, cost-saving reasons were found to have a significant effect upon most villagers' use of the UC card. However, for the rich, this was not the only factor. This is evidenced by the remarkably high percentage of non usage among the rich villagers particularly in the non-remote village that was seen in data from the questionnaire and interviews. The majority of people in this group showed the highest

preference for clinics owing to the perception that the services provided through the UC card did not provide as good a quality of service as those received from private providers. Another reason given was that these villagers also had private health insurance through their own or through other family members' employment. Their private insurance in general offered a wider range of health services some of which were not accessible under the UC scheme, for example, villagers could attend any hospital they preferred or could claim compensation after an accident.

A wealthy man explained the reasons why he had never used the UC card:

'I used to go to hospital since I didn't have the gold card. At that time I had a stomach ache and had a fever. Instead of diagnosis, he asked me if I have ever been to any clinic before I came to see him. I said yes. He asked me what the doctor there told me. I told him the doctor said I had kidney problem. He said to me, 'I think you have a kidney problem,' but never did any analysis. I don't like it as the doctor was only thinking of the money. I was so angry and since then I have never gone back to that hospital and have been using clinics when I got sick. I paid more but I think it is better' (Male 64 years old 27 November 2005).

A similar reason was given by another rich informant from the same village. This villager preferred to go to clinics or well-known hospitals despite the fact of having to pay for the medical fees. This was exemplified by the following statement:

'I've got a gold card but I've never used it. I've got a stomach ulcer and I used to seek medical care from a local health centre. Whenever I went there, I was always given the same medicine that doesn't ever help. Also, I had to wait for ages. When I went to a clinic, it was very different as I could see a doctor even if it was 8 am. I paid 800-900 Baht each time and I got some medicine which was very good. I'm now fully recovered after having taken Doctor [NAME]'s medicine (Female, 61 years old 23 November 2005).

These examples confirmed the idea that purchasing power provided people with more alternatives. The rich villagers enjoyed privileged access to healthcare with a better choice of services owing to their ability to pay, whilst the poor had limited options and had to accept the UC card and its services.

### Having traditional healthcare available

Traditional healthcare still appeared to be popular among some villagers, especially those from the older and middle age groups. These people decided not to make use of the cards for health conditions where they believed that modern healthcare was not really effective, and thus they turned to traditional medicines. The study found that elderly and middle age people from both villages continued to have considerable trust in traditional methods of treatment as seen in this first example from the remote village. A man with diabetes was resorting to traditional medicine, ie. using herbs, owing to the perceived ineffectiveness of ‘modern’ treatments:

‘My condition got worse. The cure wasn't sufficient. I couldn't work or even walk [He asked the researcher whether the researcher remembered him as the last time the researcher saw him in late 2003 he was ill in bed] and I had to stay home. Another thing was I couldn't even see properly. This time I made my decision to not rely on the doctors and hospital. Now I have found my way to cure myself and I have been getting much better because of this herb I have been taking. I paid 400 Baht per plant. I think I will expand the production of this plant if it works well with me to ‘*Tam Boon*’<sup>72</sup> by giving it to other patients, who also suffer from diabetes’ (Male 65 years old 21 November 2005).

A female informant from the non-remote village, who had a chronic illness that had not improved, despite a lengthy period of modern treatment, decided to return to traditional doctors and herbal medicines that she used in conjunction with massage. She explained that:

‘I’ve been suffering from heart disease and diabetes for several years. My heart has not been in good condition since my son passed away. I’ve always received treatment by doctors. They gave me some medicine but I didn’t get any better so I asked [NAME] (a traditional massage therapist) to massage certain lines related to the heart. Now my condition has improved. I can travel and get back to work’ (Female, 58 years old, 11 February 2005).

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<sup>72</sup> Usually refers to the Thai Buddhist ceremony whereby one receives merit by offering food to monks, but in this sense it refers to the merit gained from helping others. A ‘good’ deed is believed to help people maintain their wellbeing.

This was also the choice for the older people in the same village who still required traditional treatments such as herbal remedies. However, they were restricted in their ability to rely on this option, because of the urbanisation of their village which had reduced the number of local healers that were available:

‘There is no herbal doctor these days. If there was still this kind of doctor, I would want to go and see him. These days when people get sick, they would usually go straight to see a doctor in the city. Herbs are good when you boil them with water and drink it. But the herbs grow too far away and I can’t go to get it because my legs are not strong enough. In the old days, I would go and find the herbs by myself. But now, even if I walked half way, I would feel tired. I can’t walk anymore. My legs are not that strong.’ (Male, 84 years old 23 November 2005).

Another informant from the non-remote village viewed traditional styles of treatment such as *Yuu-Fai* (see Chapter 5) as enhancing women’s health. She believed that the reason why she was at that time experiencing poor health was because she had not gone through such a process and she explained that this was because modern people preferred convenience and did not want to waste time on such things. She emphasised:

‘people nowadays are lazy. They only want something fast and convenient. That’s why they aren’t as healthy as those in the past.’ (Female, 52 years old 24 November 2005).

#### **7.2.2.4 Low quality facilities**

Questionnaire and interview data suggested that the low quality of healthcare provided by the scheme had the effect of discouraging some villagers from using the UC cards. Whilst many continued to put up with the low quality of the healthcare on offer, several people refused to use the cards owing to the perception that a free product usually was of low quality. The criticism made about the quality of services in general was that the quality of medical treatment under the UC scheme was comparatively lower than that acquired from other sources, such as private clinics or hospitals. It is not surprising that

non-remote villagers were more critical of the services because they had greater experience in accessing various healthcare alternatives and thus had developed higher expectations. This would help explain the lower percentage of card usage in this area, i.e. in the non-remote location.

Moreover, many villagers, including the poor, considered that the use of the UC was stigmatising because of its association with poverty. It was found that a number of villagers thought that ‘the 30 Baht is a scheme for poor people’ and they tended to doubt its quality, often with justification. Low quality service was the main concern for many villagers and this made some reluctant to utilise the card. For instance, a female villager from the remote village sometimes preferred to seek medical care from private hospitals, because she was convinced that they provided a higher quality service; despite the fact that she had a low income.

‘Everyone in my family has got gold cards because the doctors from a local health centre came here and provided them. But, we don’t like to use them because it’s a waste of time. We have to queue. The gold card is good in that it’s free but when I take the medicine given by hospital [C] the symptom persists. It seems as if the disease is not scared of the medicine. But when I go to hospital [D], I pay 400 Baht and I’m cured. Doctors at hospital C speak impolitely so it’s better to avoid them’ (Female 55 years old 16 November 2005).

A wealthy male villager from the same location felt that:

‘Private hospitals are better, faster, and have good medicine. It’s normal. Because the medicine is more expensive, it’s more effective. I went there when I was ill. I paid 2,000 Baht and I got better. (Male 65 years old 18 November 2005).

A similar narrative was provided by a female informant from the non-remote village who preferred to pay for a better service, even though she was poor. She said:

‘If I can choose between a hospital and a clinic, I will go for the clinic as they gave a better service both in the doctor’s examination and at the reception. I am more satisfied with the clinic service than the hospital, even if I have to pay



more. Every week I have to go to the clinic and I have to pay 100 – 200 Baht’ (Female 59 years old 23 November 2005).

Another related factor may be attributed to what one respondent called the ‘class system in Thai society’. That is to say, those labelled as poor, so it was thought, tended to receive poorer treatment, as described by non-remote villagers in the following examples.

‘Doctors tend not to provide good care for us who use the 30 Baht card because we spend little money, unlike rich people who pay the full amount, doctors are likely to give them better treatment. There are positive and negative points of paying cheap medical fees’ (Female, 18 years old 26 November 2005).

‘There is a class system in Thai society. Wealthy people tend to get very good, prompt healthcare treatment. But poor people who have to wait for financially supported help from the government are unlikely to get equally good service. This is because hospitals don’t get much profit. Business is a profit-making activity. They get a lower profit from being funded by the government. Just to be clear, even welcoming conversations are different. To the rich they’d say...The doctor has asked you to come this way please...but the poor would be rudely told to get queuing tickets and wait. This is common.’ (Male, 25 years old 27 November 2005).

These examples show that the UC card was sometimes regarded in relation to the issues of social class and poverty. Some villagers perceived the UC cards to be low priced, freely available and probably offering a low-quality product. However, in reality, regardless of social class and income, everyone wanted to receive the same quality of care as that offered to those people who could afford to pay and those who benefited from other healthcare insurance schemes that were provided by state. This perspective may have had a significant impact on the villagers’ decision not to use the UC card. Moreover, many villagers believed that products that were given to them free of charge were usually not as good as those they needed to pay for. A number of villagers therefore preferred to spend their own money in order get what they thought was a better quality of service.

### **7.2.2.5 Gender culture**

This section explores the villagers' perceptions of gender and health and the way in which these have generated negative effects upon healthcare behaviour as well as upon opportunities for card usage. In certain circumstances, culture became an obstacle for villagers with respect to using the card.

Referring to Chapter 5, gender has influenced the way in which villagers access healthcare. This section investigates the use of the UC cards in relation to gender culture. The following examples clearly illustrate the way in which gender culture shaped the attitudes and behaviours amongst the villagers.

#### **Exploring the case of men:**

##### **'Macho' men are not supposed to frequently visit doctors.**

From the villagers' gender culture (see Chapter 5), being a man meant one had to 'be strong'. A man's responsibility was to be the head of the family. Being a woman meant that one had to be 'well mannered'. A woman had to look after the family, including the extended family. Consequently, some of the ways in which male villagers were socialised could lead to behaviours such as drinking or refusing treatments that could potentially cause risks to the individual's health, as illustrated by the examples below.

#### **Example 1**

A 5 year old boy came with his grandmother when the researcher was conducting a focus group on women and health. He looked pale and very skinny owing to his heart disease. The researcher asked his grandmother about him for a while and then talked with him. He said that when he went to see the doctor, and was given an injection, his mother had told him that 'strong boys don't cry, so he must not cry' even though he was in pain (Male 5 years old 7 February 2005).

## Example 2

During a focus group discussion held with male participants they showed what it meant to be a typical man. An 18 year old told me ‘You can notice where boys are hanging out by looking for smoke [from cigarettes] and noise when they get drunk’. In-depth interviews highlighted the risks associated with manhood in particular for young men from the non-remote village ‘my health risk occurs when I am out clubbing, I smoke, drink, and have unprotected sex’, (Male 25 years old 7 February 2005).

## Example 3

The researcher had the opportunity to observe a villager’s health seeking behaviour by going to a local health centre with *Phi Sun*, with whom the researcher was living while she was staying in *Baan* remote. She asked the researcher to accompany her when she went to see a doctor. She had had muscle pain for months and the health worker prescribed painkillers - paracetamol. She also told the health worker that her husband had also been sick for a while and she needed medicine for him. When the health worker asked her why the husband did not go to the doctor himself, *Phi Sun* told the health worker that he was always busy and that she had told him many times to see the doctor but he did not want to come. The health worker asked about her husband’s symptoms, and finally, gave her some medicine for him (Researcher’s filed note 2005).

These three examples suggest that firstly; men usually did not look after themselves sufficiently because they perceived they had the responsibility to be strong, even when they were sick. Secondly, women were considered to be responsible for men’s health and illnesses throughout their lives, as seen in the first example when a mother took her son to see the doctor and in the last when a wife asked the doctor for medicine for her husband.

Moreover, according to nationally collected data, it appears that whilst men’s lifestyles are riskier to health, they attended the doctor less frequently than women. A UNDP report (2003) in Thailand showed that in 2001 men led unhealthier lifestyles than women (60.5 % as compared to 10.2%) while the MoPH has reported that men’s lifestyles are much riskier to health than women’s. For example, the amount of alcohol consumed by Thai males was ranked first in Asia and fifth in the world (MoPH, 2004). It may be surmised that Thai men are ‘culturally’ less likely to be health-conscious, that

is to say men are allowed to drink and/or smoke as they please, but the same does not hold true for women (see Chapter 2 and Chapter 5).

**In certain circumstances, women are too embarrassed to visit doctors.**

Although this thesis found that women see doctors and used the UC card more frequently than men, in some cases women did not want to attend for medical care. This was related to gender issues especially those concerning illnesses of the female genitalia which if not treated could increase women's exposure to health risks. For example, although there has been considerable debate about the importance of the cervical screening test in prevent cervical cancer, very few women have been screened. Moreover, a study into the implementation and coverage achieved by Thailand's cervical screening programme pointed out that, to date, the programmes have been poorly targeted and have provided very limited information to clients (Phommo 2005).

Although at the time of survey for this thesis the UC scheme had provided free preventative cervical cancer testing to women in the two communities, many women had found that it was not easy to overcome their embarrassment and take the test. From the researcher's observation while interviewing women, the researcher found that many women are shy when they talked about this issue. One woman said that the lack of female doctors and health workers in her local health centre discouraged her and other females from seeking treatment:

'I prefer talking to women as I can be more open about my condition with them'  
(Female, 40 years old 24 February 2005).

This finding is supported by the study of Phillips and Brooks (1998) that women tend to prefer to have female general practitioners (GPs).

Another woman said 'I don't want to go because the doctor is someone I know' (Female, 61 years old 24 November 2005). More importantly, none of the women whom the researcher interviewed (12 cases) had taken this screening test. These examples indicated that, like men, some women also experienced health risks related to their culturally defined role and fulfilling this role mattered more to them than potential risks to their physical health.

The above findings demonstrate that the villagers' decisions to visit medical practitioners, which in turn, provided opportunities to utilise the cards, are underpinned by the issues of gender perception and health. The distinction between both male health and illnesses and female health and illness is related to a particular understanding of masculinity and femininity in the Thai context. In other words, it was the notion of femininity and masculinity rather than the actual health conditions that determined whether people visited the doctor or not. More importantly, in some situations, the way in which femininity and masculinity have been conceptually defined discouraged villagers from taking good care of their health and from using the UC card.

In summary, the villagers' meaningful actions to use or not to use the UC card were determined by both their judgment and action and these are displayed as four categories according to the different characteristics as shown in Table 7.7

Table 7.7 Villagers' thinking and action

Action	Positive perceptions of UC	Negative perceptions of UC
<b>Using the card</b> (69.4%)	1. Positive, <b>Using the card</b>	3. Negative, <b>Using the card</b>
<b>Not using the card</b> (30.6%)	2. Positive, <b>Not using the card</b>	4. Negative, <b>Not using the card</b>

1. The first group represents the majority of villagers who have a positive perception towards the UC card and have used it. Most of these villagers are people who are in the remote location, women, and are in the low-income group.

2. The second group represents villagers who have a positive perception towards the UC card and view the scheme as beneficial. However, they prefer using other alternatives. They are: villagers in the non-remote location and those in the high-income group who have more choices and the ability to pay.

3. The third group represents villagers who have a negative view, but the UC scheme is the only choice that they have the capacity to use. They are: villagers from both sites with different identities who used the card but many of them have complained about its quality.

4. The last and fourth group represents those who have a negative perception towards the scheme and prefer not to use the card. They are people such as the high-income group who have private health insurance or can use other, better alternatives. The UC card is regarded as a low-priced product of inferior quality.

In summary, there were many factors that were found to have had a considerable influence on the villagers' meaningful actions in card usage and card non usage. The main reason for using the UC card was found to be that villagers could not afford to pay for expensive medical services without it. This may explain why the poor in both villages constituted the greatest number of card users. In addition, the poor from the remote site had a slightly higher percentage of card usage than from the non-remote one, although in general they were less able to afford transport to remote facilities. In contrast, it was the rich in the non-remote village who enjoyed more choice over whether or not to employ the card than those in other economic classes, because of their wealth and the availability of alternative schemes and provision of services. Apart from the factor of economic class, it has emerged that there were other potential factors that formed important barriers to UC card usage for both villages. These factors included: the perception that the illness was trivial, opportunity costs of attending healthcare facilities, personal preference, low quality facilities, and cultural factors that is to say, what were thought of as appropriate or inappropriate activities for men and women.

## **7.3 Conclusion**

This chapter has analysed how the UC contributed to villagers' satisfaction through the villagers' actual experiences and their perceptions of using the UC card. It was found that most villagers who employed the card had increased satisfaction regarding healthcare provided under the UC scheme and the prime reason given for this was its low cost. There have been several improvements in terms of service provision since the

scheme has implemented. However, the most important contribution to villagers' satisfaction came about because the scheme was perceived as providing security in life.

The findings have indicated that the majority of villagers were satisfied with the card, in particular women and the poor villagers in both locations were more satisfied than men and other economic groups. The relatively high satisfaction reported amongst women can be explained on the basis of their gender role in their families, in that they play the role of looking after the needs of the family, especially its health. Regarding the poor, when the scheme enabled them to access healthcare with less worry about costs, it created a sense of security in terms of their economic and emotional needs.

However, it was found that some of the villagers were not satisfied with using the UC scheme, as they viewed it as offering a lower quality care and providing more limited service options than other existing healthcare systems, i.e. CSMBS and SSS that have been provided to the rest of population by the state.

Villagers used the UC card for a variety of reasons, but the main reason was to help them afford healthcare. Most importantly, the UC scheme was recognised not only as helping villagers in saving on medical expenses, but also in saving the lives of those who had previously not had enough money to pay for healthcare services. This explains why the highest rate of using the UC card was amongst women and the poor villagers from both areas. The UC cards were used when villagers were faced with 'serious illness' and to obtain preventative healthcare such as children's vaccinations and contraception.

However, in some circumstances, villagers did not use the UC card and several explanations were given: minor sicknesses, the issue of opportunity cost, alternative choices, lower quality on offer and the influence of culture. Having minor levels of sickness was the main reason for non use, followed by the issue of opportunity cost. It transpired that the rich and non-remote villagers who had more choices decided to exercise their meaningful actions by using the various alternative healthcare sources. Moreover, some of the card non users in *Baan* non-remote preferred to use alternative provision so as to reduce the time caused by queues, that is for them it was an opportunity cost issue, because they did not want to lose income unnecessarily. Another important reason that prevented villagers' use of the UC card was its reputation

of being associated with ‘low priced goods’ and ‘free handouts’. The last explanation is concerned with gender cultures, for example, men who were reluctant to go to doctors even when ill and women who avoided going to the doctor with gynecological problems are instances that demonstrate how gender norms influenced health.

In summary, the UC scheme has contributed to the sense of life satisfaction among villagers, whether or not they used it, as it has increased their capabilities and economic security, thus reducing their fear of threats to their health and wellbeing.

Moreover, the high level of satisfaction brought about by the existence of the UC scheme has been shown to be linked to the Thai culture involving Buddhist teachings and the King’s philosophy of ‘sufficient living’. That is, people in rural areas are grateful for any provision of goods or services that improve their lives and those of their families and have a tendency not to be too critical.

It is interesting to find that even for those who did not make use of the UC card, the UC scheme still played a crucial part in their life satisfaction, as a reserve resource for accessing healthcare when they needed it. Thus, it has emerged that it is important for healthcare policy makers to devise ways of making the system more attractive to non users, by improving the quality and methods of delivery. In the next Chapter the conclusions to this research will be presented. In addition policy implications, recommendations for future research and some of the limitations of this thesis will be addressed.



## Chapter 8: Discussion and Conclusion

At the beginning of this thesis the research question was set out: to what extent has the existing UC scheme contributed to the wellbeing of villagers in rural Thailand? This question was motivated by debates surrounding the impact of the UC scheme and the obvious controversy over the arguments for and against it. These debates have coincided with Thailand's increasing prioritisation of wellbeing as a goal of national development, such that in the health sector, wellbeing is seen as the desired outcome of the UC scheme. This thesis, therefore, investigated these phenomena by assessing the extent to which the UC scheme has contributed to the villagers' wellbeing. This assessment has used the wellbeing concept proposed by the WeD research group (Gough and McGregor, 2007) as the conceptual basis of a WFE approach and developed a related methodological toolkit. The WFE was used to assess the UC scheme against the following three criteria: needs met, acting meaningfully in pursuit of goals and experiencing satisfaction with life.

Based on eight months of ethnographic studies in one non-remote and one remote village in Northeast Thailand the research included: a detailed survey of 216 villagers, 24 in-depth interviews (12 men and 12 women), 6 focus group discussions and participant observation, and interviews with policy makers and healthcare workers, as well as data from the WeD project. The results have shown that the UC scheme has made a valuable contribution to the conditions (McGregor, 2008) within which villagers in rural Thailand can achieve a greater degree of wellbeing, and in particular, in relation to the terms that are set out in the WeD definition which lists three criteria (Gough and McGregor, 2007) as mentioned above. It was found that more villagers' healthcare needs are being met because the majority of respondents who had the right to access the UC, held UC cards. Additionally, in both villages, most of the villagers who held the UC card, used it. Therefore, in terms of uptake and use of the card, the scheme has been successful, in particular in helping those who had limited access to healthcare before the UC scheme was introduced, as indicated by the fact that those with the greatest healthcare needs, such as the poor, women and those living in the remote community, showed the highest percentage of card usage.

More importantly, it emerged that, in both locations, most of the villagers who had used the card were satisfied with the scheme as a whole and most considered the UC scheme

as being better than previous schemes. This is because they felt the UC scheme had provided affordable healthcare and had increased their security more than any other previous scheme and thus relieved their anxiety about paying for healthcare should they fall ill. It was also found that women were significantly more satisfied with the UC scheme than men and the poor were more satisfied with the scheme in comparison to other economic classes. This thesis found that although not everybody who held the card actually used it to access healthcare services, they still reported being satisfied with having it. Therefore it can be concluded that most villagers experienced a better sense of wellbeing as a result of the UC scheme.

The concluding chapter is divided into five sections. The first section begins with some more details of the key findings. The second part discusses the scheme's strengths and weakness from the villagers' point of view. The third part discusses the extent to which a 'Wellbeing Focused Evaluation' has added value to healthcare evaluation practice in Thailand. The discussion focuses on how this approach draws together diverse information relating to the three dimensions of the approach, these being: having, doing and thinking/feeling, as introduced in Chapter 3, and outlines some of the limitations of this approach. The thesis concludes by highlighting some policy implications and the chapter ends with some proposals for future research.

## **8.1 The extent of the UC scheme's contribution to villagers' wellbeing**

### ***8.1.1 The first aspect: needs met***

This section investigates whether and to what extent villagers' healthcare needs are being met as a result of the UC scheme. The following figures suggest that, given the importance attached to membership of the UC scheme in the individual interviews, many of the villagers' healthcare needs were being met.

Firstly, a majority, approximately 83.2%, of those respondents who had the right to access the UC scheme, possessed a card. In terms of the distribution of each card type there was no difference between the non-remote and remote village and the take up in each village of free cards was double that of co-payment cards, 66.7% against 33.3%, respectively.

Secondly, regarding differences in location, gender, age, and economic class, it was found that in both locations, free cards were possessed by the poor and women in higher proportions than other economic groups and men. That is to say, the conclusion can be drawn that the card has been taken up by many of the most vulnerable people in the villages.

However, it has emerged from this research that not every eligible villager in both villages held a UC card. Two key reasons have been given for this. Firstly, the villagers' decisions were sometimes related to geographical factors, such as the fact that those living in non-remote areas had access to alternative healthcare and those who migrated to work in other provinces also had other arrangements available to them, and these both affected the level of card uptake. Secondly, there was the failure of the UC management system to provide cards to those who were entitled to them.

In addition, not every villager who held a card chose to use it. According to Doyal and Gough (1991), if healthcare is available and people are choosing not to utilise it, the appropriateness of the provision needs to be considered, thus in measuring its appropriateness one needs to consider 'utilisation'. Utilisation is one part of 'meaningful action' (the second aspect of wellbeing, see Chapter 3), and is addressed here.

### ***8.1.2 The second aspect: Acting meaningfully in pursuit of goals***

The ways in which the UC scheme has enabled villagers to pursue their health goals are now considered. The question is: have the villagers been utilising the UC card as a means to achieve their health goals?

It was found that the UC scheme has enabled villagers to act meaningfully in pursuing their health goals in several ways.

Firstly, the UC scheme has encouraged most people to access healthcare. The possession of the UC card has allowed most villagers access to healthcare and this study

found that a significant number (approximately 70%) of the respondents from both villages who held the UC card, had used it.

Secondly, most of the UC card users are poor. The UC scheme has increased the number of options for villagers to use healthcare, and this has been particularly helpful for the more vulnerable groups with the greatest healthcare needs, such as the poor and women, as attested to by the fact that these groups demonstrated the highest percentages of card usage. Previously, these people would either have had to pay expensive fees or forego getting treatment, and now with the UC card, they can opt to use the scheme. Furthermore, the high usage of cards for these groups indicates that not only are they able to act meaningfully in principle, owing to the existence of the scheme, but they have been doing so in practice. This finding is supported by other studies of the UC scheme, in that it has emerged as being greatly beneficial to the poor (National Economic and Social Advisory Council (NESAC), 2004; Tangcharoensathien and Prakongsai 2005; Limwattananon et al., 2007; Pannarunothai 2008; and Somkotra and Lagreda, 2008)

Thirdly, it has facilitated access to healthcare for those living in remote communities. Findings reveal that remote villagers were exhibiting a higher percentage of card usage than their non-remote counterparts, which differs from the results of previous studies. Several of these studies have found that distance from healthcare location is one of the main barriers to using health services (Khanthachai, 1983, Gwatkin, 2000, Sremsee *et al.* 2003, and Na Ra Nong, 2003). The results of this research can be explained by the fact that people living in or near urban areas have access to a greater range of healthcare services than those in the countryside, and thus they have more opportunities to utilise healthcare providers other than those that are a part of the UC scheme. This perspective is supported by figures that show that the amount of healthcare expenditure in the non-remote village, on average, was twice that in the remote village.

Fourthly, in terms of gender, the results show that more women utilised the UC card than men. This finding is interesting, given that many scholars have pointed out that women in developing countries tend to have less access to healthcare than men (Miles, 1991; Doyal, 1995:1998; Standing, 1997; Boonmongkol *et al* 1999; Annandale and Hunt, 2000; and DeLorey, 2003). This suggests that due to the UC scheme women in Thailand are getting easier healthcare access than many of their counterparts in other

developing countries. However, there are two other explanations in the Thai context that have emerged from this study that could explain this high level of female participation in healthcare in general and specifically through the UC scheme.

The first explanation is the different attitudes towards health between female and male villagers. For example, men preferred not to see the doctor regularly, whereas the women were more likely to use the health service more frequently.

The second explanation is that there were reasons other than ill health for women to see the doctor and/or use the UC cards. As discussed in previous chapters, women have sole responsibility for birth control methods, and contraception is freely available on presentation of a card. In addition, on many occasions the women had to take family members to hospital, in particular children and the elderly. Furthermore, it was found that they held a higher proportion of free cards than men and hence were less averse to seeking medical help, because they did not have to pay. Last but not least, they have traditionally controlled a large part of the household finances, regardless of who earns the money and therefore they have the decision making power to spend money on doctors' visits (Mee-Udon and Itrat, 2005, Blumberg and Mee-Udon, 2002 and Promphakping, 2000).

Nonetheless, it is worth exploring the reasons why nearly a third of the villagers interviewed (approximately 31%) had never used the UC card, even though it has been available since 2001. Apart from the matter of having only trivial illnesses, which many respondents put forward as a main reason why they had not used the card, there are several other reasons that may discourage them from doing so, ranging from economic to cultural factors, as follows.

The first reason is the opportunity cost. Using the UC card was seen as having a high opportunity cost by some, due to being time consuming and the money needed to access the UC health centres. Some villagers preferred to pay for their care themselves, because they believed that it was worth paying money to ensure they were not absent from work or anything else that they valued. The villagers who had this preference included the rich and middle class people, who had the ability to pay, and also many of those in the non-remote village and this is addressed as part of the next factor.

The second factor is a matter of geography. It was found that although the non-remote village had a slightly greater percentage of UC cardholders and had the advantage of proximity to the city and thus easy access to UC facilities, the percentage of usage was actually lower than in its remote counterpart. This is because the availability of alternative healthcare systems and the nature of the villagers' occupations, such as factory workers, resulted in less use of the UC card by the non-remote villagers.

The third reason is the UC's low quality of services. Some villagers reported that they had had direct experience of poor service provision, whereas others anticipated low quality of service, owing to the belief that free and low cost products were usually not as good as something they paid for. Although the negative perceptions regarding service quality came from villagers in every economic group, it emerged that those who had the ability to pay enjoyed a greater level of choice than villagers in other economic classes.

The last reason for not using the card concerned gender culture. It was found that both women and men were concerned about their cultural gender role more than their actual health conditions. For example, some women expressed the fact that they were too embarrassed to see a doctor to receive a cervical screening test, and some men said that if they frequently visited a doctor they could be thought of as weak and less manly. Understandably, such attitudes as these have had a negative effect on card usage.

In summary, all of the evidence taken together, in particular given the high levels of uptake and use, would suggest that the UC scheme has created better conditions for the pursuit of wellbeing amongst rural villagers (McGregor, 2008) and this has increased their capabilities in accessing healthcare, in relation to the capabilities approach of Sen (Sen, 1999). The UC scheme has contributed to villagers' wellbeing in two significant ways. Firstly, it has made significant strides in meeting their healthcare needs. Further, high numbers of the respondents in this research expressed the view that the UC scheme is seen as an important resource that they are able to command whenever they need to. Secondly, many people in both villages have increased their ability to control their lives in a more meaningful way as a result of the introduction of the UC scheme.

### **8.1.3 The third aspect: experiencing satisfaction with life**

To what extent does the healthcare provided by the UC scheme contribute to villagers' satisfaction with life as a whole?

As discussed in Chapter 7, this study found that many factors have positive effects on villagers' levels of satisfaction with their lives, such as the influences of Buddhism, the monarchy and the optimistic cultural outlook that prevails in Thailand. However, from the villagers' perspective, 'having good health' was considered a major component of their life satisfaction as a whole. Thus, the UC scheme, as a means to help people keep their good health, is expected to be another positive influential factor regarding the satisfaction levels of villagers.

In terms of satisfaction with the UC scheme, it emerged that most villagers in both locations (approximately 76%) who used the card, were satisfied with the scheme as a whole. Moreover, around 65% of villagers in both locations considered the UC scheme to be better than the previous schemes. The significant reason for the considerable satisfaction amongst the villagers was that they felt that the UC scheme had provided affordable healthcare and had increased their security more than its predecessors. That is the scheme benefited many of the participants economically, making them feel safer and enabling them to act more meaningfully, thereby increasing their level of satisfaction. Possessing the ability to restrict medical expenses can alleviate financial difficulties, at both the individual and family levels.

It was found that women in both villages were significantly more satisfied with the UC scheme than men. The poor from both villages also more satisfied with the UC scheme than other economic classes, although result was significant only for the non remote location. The higher level of satisfaction amongst women can be explained by the fact that it is the woman's role to take care of the family's health and manage household expenditure. As the scheme had benefited many of the families in this research in terms of facilitating household members to gain greater access to healthcare services and in terms of reducing costs, they expressed their opinion that it was helpful. Similarly, the poor recognised that they were spending less on healthcare than they had been before and the healthcare scheme, being affordable, had encouraged more timely use of

medical services by those who had previously been economically restricted from doing so. Thus this scheme has enhanced their wellbeing as well as their family members', which supports the view that wellbeing is a concept involving relationships with others (Gough and McGregor, 2007; Schaaf, 2007; Phillips and Berman, 2003).

However, the study also found that a considerable numbers of villagers, approximately 22%, who had used the card, were actually not satisfied with it. Three main reasons were given for this: restricted number of choices, low quality of service and discriminatory treatment. These issues will be discussed later in the section on limitations of the UC scheme.

In summary, the UC scheme has facilitated villagers in achieving their health goals of being healthy, most villagers have been content with their use of the card and this has had an effect on their satisfaction with life in general. In addition, some of the respondents in this research who held the card, but had not used it, reported being satisfied with having it as it was a resource they could rely on in case of future need. This supports the idea that the mere possession of the card has enhanced people's capacity to act meaningfully (Gough and McGregor, 2007, Sen, 1999), thus increasing the levels of satisfaction of many of the villagers. Therefore, it is argued that most villagers have experienced a greater level of satisfaction with life as a result of the UC scheme.

In relation to the effects of the UC scheme on villagers' wellbeing with regard to the three aspects illustrated above, its positive contribution has been shown to be manifested in all three. Thus, this research concludes that the UC scheme has made a significant contribution to the wellbeing of the majority of the villagers', in particular for those who use it, in that: their needs are being met, they are better able to act meaningfully and have been experiencing a higher level of satisfaction with life. It has emerged from this study that having a UC card is viewed by the villagers as a form of life insurance for an affordable cost, which they can use whenever they need to. In addition, it has enhanced the level of security in the lives of the villagers and their families, which has been posited as being a crucial aspect of human wellbeing (Sen, 1999, Alkire, 2003, Gasper, 2005, Wood, 2008) and thus contributes to their perceived wellbeing individually and collectively. This thesis has also found that even those who have never used the UC card, still feel that the UC scheme has increased their sense of



security. This issue is particular important and thus will be discussed in more detail in Section 8.4 (Policy implications).

## **8.2 Strengths and weaknesses of the UC scheme**

From the villagers' perspective a number of features of the UC scheme were considered to be strengths.

### ***8.2.1 Strengths of the UC scheme***

The most notable strength of the UC scheme has already been discussed above in that it has enhanced villagers' wellbeing by providing affordable healthcare and has enhanced feelings of security amongst villagers. It has contributed to different aspects of wellbeing in terms of objective, subjective and relational dimensions. The 'objective' dimension, in other words the material aspect of wellbeing, refers to having local healthcare centres, healthcare workers, medicines and medical services which villagers can access whenever they need to. The 'subjective' dimension refers to the sense of security provided by these services, and the way in which it increases their feeling of control over their actions and their lives as a whole, which is an improvement on previous healthcare schemes. When the subjective and material aspects are integrated, it also has a positive effect on relationships within the family and the community.

Most importantly, there have been major improvements in terms of the quality of the healthcare services provided under the UC scheme. As presented in Chapter 2, many actions have been taken by various governments. For instance, firstly, patients' rights were established under the National Health Act and through this they are entitled to compensation in the case of medical malpractice, as was widely explained in a television campaign. Secondly, the HA (Hospital Accreditation) has been applied in many hospitals in order to standardise services. Thirdly, many extra services such as ambulances, 'complaints boxes', have been provided for some hospitals. Under new arrangements such as these, some of the villagers have claimed that they are receiving a better service and are treated with more respect than they were previously.

### **8.2.1 Weaknesses of the UC scheme**

In spite of these reported strengths of the UC scheme and its related healthcare provision, there are still a number of weaknesses that need to be addressed.

The first criticism of the scheme is that it has restricted people's choice, which is considered a vital dimension of human wellbeing, both in the literature and in the opinion of the respondents, thus this aspect has created dissatisfaction for those using the scheme. Although these limitations regarding the choice of health service have now been removed in cases of emergency, they are still a problem in normal circumstances.

The second limitation is the issue of loss of time or the opportunity cost, when seeking healthcare. Going to see a doctor and using the UC card was perceived by a number of the respondents in this study as to be more time-consuming as they were required to queue for the services, and for many people a waste of time means a loss of earnings.

The third reported weakness is the perceived low quality of services. Some villagers did not trust the quality of services, in terms of the medicines available and the quality of care given by the medical professionals. Many people clarified that the UC card was meant for poor people. Thus, merely basic medicines such as paracetamols were given, which were perceived by the villagers as having no effective results. Additionally, the UC card itself is regarded as a low-priced product that is consequently of inferior quality. This issue of poor value services has undermined the confidence in the quality of service providers under the UC scheme.

The fourth shortcoming of the UC scheme is that there have been reported instances of discriminatory treatment. Some villagers felt they had been discriminated against in using the UC card because of their low economic level. In particular, they considered this to be so when they compared what they received, with what would be received by those using the other two governmental healthcare schemes, i.e. CSMBS and SSS, that are available for other Thai citizens.

In conclusion, the UC scheme may not be the best healthcare system because of the poor quality of service on offer, and because many problems still exist, as explained

earlier. However, for many villagers in the two research sites, this scheme is viewed as the best they are able to access. The UC scheme has not only increased the options to access healthcare amongst villagers, as found in this study, but it has also created better conditions for Thai people at a national level. This is supported by the large number of people who have signed up for the scheme, a number that increased from 45.4 million to 47.7 million between 2002 and 2004 (The National Health Security Office, NHSO, 2003; Siamwally, 2004). These figures show that more than two thirds of the Thai population (63 million, approximately) are covered by the scheme and this scheme could therefore make a difference not only to the health but also the wellbeing of many Thai people.

## **8.3 Benefits and limitations of a ‘Wellbeing Focused Evaluation Approach’**

### ***8.3.1 Benefits of a Wellbeing Focused Evaluation Approach***

This thesis has provided a detailed evaluation of the wellbeing of villagers in Northeast Thailand through their experience of having a health card, using their health card to access healthcare (‘doing’), and reflecting on their experience of UC healthcare (‘thinking/feeling’). A WFE approach is used to understand these processes and the benefits of the WFE are discussed here. As discussed in chapter 3, the WFE is not only a conceptual tool, but also a method that can be used to assess villagers’ wellbeing by examining how villagers use resources to meet their needs, achieve meaningful goals and attain a satisfactory quality of life. The following section describes six elements of the WFE which enable researchers to gain a holistic understanding of villagers’ wellbeing and discusses the benefits of the WFE.

Firstly, it has helped to explore how the scheme is meeting villagers’ healthcare needs, enabling them to act meaningfully to pursue their health goals and increasing their life satisfaction, thus contributing to a better level of wellbeing. Although it cannot be claimed that the WFE would be universally successful, it has been found to add to a greater understanding of the broader context of the impact of the UC scheme on the villagers in the research sites. By recognising the social and cultural context within which the UC scheme is implemented, the WFE shows that this low cost healthcare is considered as a safeguard to prevent villagers from serious harm in their life that might occur if they were to fall sick and were unable to afford expensive healthcare.

Secondly, the WFE has taken a multi-method approach, using questionnaires, interviews, focus groups, surveys, and participant observation. Using a multi-method approach has helped to gain better understanding of the topic of villagers' wellbeing. For example, the quantitative method is suitable for analysing and comparing the contexts of villagers, whereas a qualitative investigative process is appropriate for applying the individual life experiences and perceptions of the villagers in relation to the UC scheme. In this respect, the researcher may find the approach flexible enough to apply to different contexts and situations.

Thirdly, with its comprehensive analysis of the three aspects of wellbeing through a process of 'thick description' (Geertz, 1973), which involves describing and interpreting the meaning of the findings found in the research, it should bring a richer understanding of the concept in relation to the villagers that were surveyed and therefore expands on conventional evaluations, such as the ABAC satisfaction polls. The WFE is more holistic as it addresses multiple valued dimensions of people's wellbeing, namely their objective circumstance (material outcomes from having and using the UC card), subjective experiences (feelings, perceptions and satisfaction in relation to having and using the scheme) and relationships (the contexts of the villagers, such as social relations and culture). As argued in Chapter 3, a key weakness of previous evaluations of the effects of the UC scheme in Thailand, e.g. by the ABAC poll, has been the reliance on satisfaction scales, which some have argued accounts for the extremely positive results of these evaluations. With a combination of objective and subjective measures, the WFE enables the evaluator to cross check the data through the more triangular nature of the tool, which may reduce the inflationary results from the satisfaction approach, as has been suggested by many scholars (Avis *et al.* 1997; Williams 1994; Williams *et al.*, 1998;).

Fourthly, the WFE has not only brought a broader concept into the UC scheme evaluation, but also it makes possible to obtain a more positive and realistic sense of evaluation. As discussed in Chapter 3, the problem with the conventional healthcare evaluation in Thailand is that it had negative effects on health administrators' motivation. This is because conventional healthcare evaluation is time-limited and involves inappropriate indicators (i.e. an improvement of health status within a short period of time, such as within one year), which can be unrealistic. The WFE is more

advanced in that its wider concept of wellbeing refers to a broader concept of health, which encompasses objective, subjective and social relations.

Fifthly, the WFE has applied conceptual and methodological insights from an international research programme into researching wellbeing in developing countries (WeD). This project developed this framework from four developing countries including Thailand by capturing wellbeing in terms of villagers views and experiences. This approach is derived from the Thai context so it is applicable for this study investigating how villagers perceive their wellbeing through having and using the UC scheme. In addition and in line with many scholars, the WFE goes beyond the individual dimensions to account for the social and relational dimensions of wellbeing (Newton 2007; Gough and McGregor 2007; Copestake and Wood 2007, Phillips and Berman 2003, Berman and Phillips 2000).

Finally, the WFE is appropriate for the evaluation of the UC scheme as it resonates with the Thai Government and the health sectors which are attempting to make it a policy goal to enhance the wellbeing of Thai citizens. In addition, to date no research has been conducted in evaluating the extent of the UC scheme's contribution to villagers' wellbeing. Therefore, if the Thai government wants to take wellbeing seriously, as stated in the national goal of focusing on people and their wellbeing, it would do well to consider the wider dimensions identified in the WFE approach, which offers significant potential to further our understanding about the relationship between health and wellbeing.

### ***8.3.2 Limitations of a Wellbeing Focused Evaluation Approach***

The WFE has contributed useful research into the evaluation of the UC scheme as discussed above. This section considers its limitations and areas where the research may be less applicable.

Firstly, in this thesis the WFE has been used within a small number of study sites and with a small number of participants within a specific social and cultural context in the northeast of Thailand. As such, there could be doubts about the power of the conclusions that can be drawn by simply generalising these results. However, as discussed in the methodology chapter this thesis attempts to understand the impact on

wellbeing from the villagers' perspectives. A rich body of data from in-depth interviews with local people, in which the researcher has research experience and understands the language and culture, can help achieve the research goals and mitigate the problems of using a small sample. Another difficulty in applying this approach to a greater number of participants in this research study were the constraints on time and resources.

Secondly, the WFE has been employed to evaluate wellbeing outcomes achieved by villagers through the process of having, using and thinking about the UC scheme at only one point in time. To gain an understanding of dynamic processes of evaluation, it would be necessary to consider secondary data which demonstrates changes in people's wellbeing, for example before and after the implementation of the UC scheme. While it might be possible to draw such data at the village level in the current study, in fact data from the local healthcare centres only goes back as far as 2003 and 2005, so no clear trends can be discerned. Considering the practical side, gathering such data was beyond the scope of this study due to limited time and resources.

Thirdly, there may be difficulties in applying this approach in less stable urban environments. This is because the WFE was used in rural based settings where villagers were interviewed individually and in depth. Although this has provided richer descriptions of villagers' wellbeing, it may not be easy to use this approach in urban situations in which people tend to be more occupied by work and thus have less time available to be interviewed. In this situation, the open ended short form of questionnaire could be used instead of the interview method. This could be delivered by post or through other available channels such as electronic mail. However, this method could only be taken to assess those who have the ability to read and write, which could be expected for more urban dwellers. This would give people the ability to explain their feelings, opinions and experiences of the UC scheme in their own free time and familiar setting.

Fourthly, in this research, both female and male villagers were carefully selected in order to reflect the voices of the villagers, however there were some difficulties which should be noted. First of all, some difficulties originated from my being a 'female researcher'. This provided the benefit of understanding the life experiences of many of the women, but on the other hand it was more difficult to apply this to the men, owing to the reasons of gender culture in Thailand, where it is inappropriate for female

researchers to interview men in particularly in focus group discussions. To solve the problem the researcher had to find male research assistants to organise the discussion and to ask the men some difficult questions related to gender and health.

Finally, although the wellbeing concept used in WeD is built on the context of developing countries, this concept may be criticised as ‘not really Thai’. In Thailand the wellbeing concept is widespread at the national level but as yet there is no agreed understanding about what it is in the Thai context. For example, in the health sector, the concept of wellbeing has been increasingly a matter of concern. In 2007 the National Health Commission (NHC), according to the National Health Act B.E. 2550 (2007), was formed to foster this perspective under the slogan ‘Synergy to Wellbeing’. One of the six duties of the NHC is to ‘to promote health assembly on a specific locality or health assembly on a specific topic and to organize the national health assembly as a participatory process leading to proposal of public health policy for the well-being and happiness of the general public’ (NHC, 2009). In order to build an approach which is derived from the Thai context, the wellbeing concept from policy makers, academics, and researchers needs to be integrated with practical knowledge from local wisdom within Thailand.

## **8.4 Policy implications**

Although findings from this thesis highlight the fact that the UC scheme has provided better access to healthcare and has contributed to a greater sense of security for the majority of villagers, particularly those who are less well-off and had very limited access to healthcare before the scheme was implemented, there are many other aspects that need to be considered. The implications of the findings from this thesis are summarised here to provide options for policy makers to improve the UC scheme.

Firstly, policy makers should seriously consider the provision of a single scheme to all Thai citizens in order to break down barriers of different standards in governmental healthcare policies.

The study found that although the UC scheme aims to give universal access to villagers, the poor are clearly benefiting the most from the scheme. However, many of the poor

still feel that they are treated in an inequitable way compared with the other two healthcare schemes provided by the government. Therefore policy makers, in order to improve the universality of healthcare in Thailand, must ensure that all Thai people are served and treated with equal respect by the government.

Secondly, attempts should be made to understand the meaningful actions of villagers in the communities, in order to find effective ways of improving the UC scheme. This thesis found that villagers used the UC scheme in a way that is meaningful for them and according to what they perceive to be the strengths of the scheme.

In this study, the villagers' meaningful actions differ according to their capabilities. This is to say they live in different conditions (e.g. distance from healthcare facilities, locations) and have different identities (e.g. gender, age, and economic class). These conditions provide different opportunities for people to hold different resources, degrees of power and abilities to achieve their wellbeing.

In terms of location, it was found that remote villagers, who live far from the healthcare facilities, have to pay more transport costs and spend more travel time than non-remote villagers, spending five times more than those in the non-remote location on travelling to the healthcare centre. Although they had much higher opportunity costs to access the UC healthcare, it was found that remote villagers employed the UC cards more than those living in non-remote areas. This is because in remote locations there was no access to a variety of healthcare service providers whereas in the non-remote location there were several options to choose from, including private clinics and hospitals.

The geographical factor was also found to have an effect on gender and age-related use. For example, women who live in rural areas have more restricted chances of receiving treatments than women who live in urban areas, since women were less likely to tolerate long journeys and the majority could not drive. In addition, due to the same reason of being less mobile, the data revealed that a lower percentage of elderly people in particular in remote location used the card than of younger people.

In terms of economic wealth, the poor have more difficulties in accessing services due to the fact that most low-income people do not own vehicles and thus rely on public transport which is time-consuming. Particularly, going to hospitals was a day trip for



those who lived far from city areas. However, the research found that a greater percentage of the poor in both villages employed the UC cards than those in medium and high income brackets.

All the above findings have significant implications for policy makers.

That is to say, although the UC scheme makes healthcare more affordable, the cost of travelling is not included. In other words, even with a free care or lower cost service such as 30 baht per visit, many villagers are still facing difficulties in using the service. However, they have no choice and thus have to deal with these problems since good health is considered a crucial factor for their wellbeing. In this way, the UC scheme has not yet fully enhanced the sense of security for the poor and vulnerable groups. Therefore, in order to increase opportunities and choices of services among these people, policy makers need to take into account geographical and economic aspects. Thus, drop-off/pick-up services would also be beneficial for those villagers who have fewer capabilities.

Thirdly, policy makers should consider the importance of the villagers' social and cultural contexts. The first point to be addressed is to understand that gender norms influence the usage of the UC card, for both men and women. For example, while men are reluctant to go to doctors even when they are ill, owing to the fear that they would be viewed as being weak, women avoid going to doctors for gynaecological problems, because they are embarrassed. Clearly the UC is beneficial to men and women but they are more concerned with cultural issues than health problems. To solve this problem the design of the scheme may need to be more sensitive to gender (Cornwall and White 2000, Pearson 2000). This might include actions such as persuading men and women to change their attitudes and recruit more female doctors (Phillips and Brooks 1998). However, it should also be noted that changing people's attitudes and behaviours is a challenging task that requires a lengthy period of time to succeed.

Another point that should be made is regarding the health promotion policy in which aerobic dance was introduced in order to promote the exercise habit to villagers. However, this exercise, which works well in more 'modern' societies such as in the non-remote village, was very comical to many villagers and this was particularly so in the remote village. For the reasons discussed here, health promotion policy should take local background into greater consideration.

Fourthly, policy makers should consider providing clearer information about the UC card and its relation to accident law. Many villagers reported misunderstandings of the eligibility criteria of the UC scheme with regard to accidents and complained during the interviews that the scheme did not truly provide the care stated in its campaign as ‘30-baht treats all disease’, since in fact they could only use the card under the condition that they held the traffic accident insurance. Thus relevant sections of the UC criteria and the act should be printed in the Isaan language and made available through the PCUs and hospitals.

Fifthly, villagers should be encouraged to share their problems and make suggestions with regard to improving health services. This should not be in a written form as many villagers are not fluent in writing Thai. Using an appropriate tool such as face emotions pictures as a way to gain villagers’ opinions regarding their level of satisfaction and any problems, should be considered.

Sixthly, the promotion of the superior quality of the UC scheme should be made known. This is in relation to the finding that many villagers did not make use of the UC card due to regarding it as a low-priced product of inferior quality. In order to promote the UC scheme among those who are not in the 1<sup>st</sup> category (positive, using the card), policy makers should increase their attention on the 2<sup>nd</sup> group (positive, not using the card), the 3<sup>rd</sup> group (negative, using the card) and the 4<sup>th</sup> group (negative, not using the card).

The seventh point, which is closely related to the sixth, is that the promotion of the superior quality of the UC should be done together with a removal of the limitations of the UC scheme. The five major issues that have already been discussed are: restricted choice, opportunity cost, low quality, discriminatory services and poor management. Of these, three issues - i.e. opportunity cost, low quality and discriminatory services - are related and it may be easy to tackle them together. For example, the low quality on offer, in terms of staff and medicine and discrimination in services, together have created a situation where people perceive using UC services to be ‘not worth it’, and consider that other healthcare systems provide better services and results. In this case, there is a need to provide a more effective service to solve these problems. The restricted choice and poor management issues also need to be solved, albeit the issue of

choice may be the most difficult. To date the debate on whether the scheme will provide more choice in the future remains an open question.

Eighthly, as this thesis has provided a detailed assessment of the UC scheme in the form of theoretical and empirical investigations, one may question how we would use it in a practical way. An open ended short form of questionnaire is proposed here in order to provide a basis for further discussion and development of the WFE evaluation. The aim is that this short form can be easily applied in a policy context and should be understood within the scope of wellbeing as discussed earlier in Chapter 3 of this thesis. As discussed in the WFE approach, in this thesis it is proposed that policy makers consider the three key criteria of wellbeing: needs met, meaningful actions and satisfaction with life. In this thesis it was also proposed that these three criteria are all inter-connected and that villagers' wellbeing can be influenced by external conditions, internal factors, relationships between villagers and their social and cultural context.

#### *1. Needs met*

Policy maker should consider the needs of the people in a specific way. The UC scheme may be designed as a one-size-fits-all but people are different in terms of identities, and their degree of control over resources. Thus these following example questions should be asked:

- Who has the card? For those who do not, why not?
- Who has used it?
- Have their healthcare needs been met?

#### *2. Meaningful Action*

When the policy is put in place, policy makers should not assume that people are necessarily able to access it. Thus the questions to be addressed are:

- Why do people use it and why do they not use it?
- Does the policy make it possible for people to be healthy?  
In what way does it do this?

#### *3. Satisfaction*

Policy makers should be aware that the policy may have different effects on different people's satisfaction levels depending on the contexts in which they are used. For example, dissatisfaction was noted to be higher among people with more options. An important issue appears to be the social context (both external and internal) in which the policy is used. Therefore these questions are worth considering:

- How satisfied are people with the policy? Has their satisfaction level increased or decreased? Why?
- How does satisfaction with the policy link to satisfaction with life?

Finally, the long term implications should be noted. Policy makers should consider formulating social policies for sustainable wellbeing in local contexts. This means the policies should meet basic needs and should empower local people to undertake, analyse and design their own social policies, as outlined by Gough (2008). In addition, policy makers should consider placing greater emphasis on social, cultural and political contexts (Gough and McGregor 2007), in particular in relation to areas with marginalised characteristics as suggested by several scholars (Copestake and Wood 2007, Phillips and Berman 2003, Berman and Phillips 2000). This would empower the people in *Isaan* region and improve their social wellbeing by creating a greater sense of social inclusion in the social policies. As Phillips and Berman (2003) argue, it is essential not only to recognise but also to emphasise the social quality of wellbeing, as it is within society and through relationships that people experience social policy provision, which has a profound affect on their wellbeing.

## 8.5 Future research

This thesis has provided a rich insight into the evaluation of the impact of the UC scheme on villagers' wellbeing within the rural context of Thailand. It does so by developing guidelines for a healthcare evaluation that focuses on wellbeing, named the Wellbeing Focused Evaluation (WFE) approach. The WFE has helped define both the positive and negative sides of the UC scheme. However, as WFE is a new evaluation technique, it will need to be further developed and refined by any evaluators who make use of it, in several ways. There are several possible directions for future research to extend the work presented in this thesis, and four main areas have been identified.

Firstly, researchers may consider extending the evaluation to a greater number of respondents which would give greater power to the conclusions drawn from the evaluations.

Secondly, the evaluation of the wellbeing of the villagers could be expanded to emphasise progress evaluation to a greater degree. As discussed earlier, this work could be extended by expanding the period of time in order to research a longitudinal perspective of how much their wellbeing has improved since the UC was implemented.

Thirdly, as identified in Chapter 2, one of the main problems of the UC scheme is that it has created more of a burden on health administrators. Therefore further study should be applied to evaluating the delivery of the UC scheme regarding the wellbeing of the administrators themselves. This is because they are very important for ensuring that the UC scheme performs well, as they are the providers. Their wellbeing is equivalent to the villagers' wellbeing, because they are a key factor in the healthcare process. Their lack of wellbeing will affect the whole process in terms of the quality of service and efficiency of the healthcare system implementation as a whole. It is important to understand the wellbeing and aspirations of these people by using the WFE.

Fourthly, the WFE should also be applied for carrying out research to investigate the wellbeing experiences of people under the other governmental schemes. The fact that there are three healthcare systems provided by the government and the UC scheme is often associated with poor people has resulted in many villagers' feeling that they are discriminated against in comparison to those people who use the other two schemes. To further understand the problem, it will be necessary to study the experiences of villagers in the other schemes. According to Siamwalla (2009)<sup>73</sup>, the Social Security Scheme (SSS) is another important scheme that needs to be investigated, because the beneficiaries invest their income into the scheme as a kind of insurance policy. They are therefore entering into a 'deal' with the healthcare system more than those people under the UC scheme and may be able to demand more return on their investment. Hence it could be valuable to use WFE to study the wellbeing of people under the SSS scheme.

This thesis has been written during a long period of political unrest in Thailand which has been going on since 2005, and during which time there have been three governments formed in 2006, 2007 and 2008. Recently, Thailand has had a new government, since December 2008, when the Democrat party came into power, replacing the Thai Rak Thai (TRT) headed by Thaksin, although political momentum in

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<sup>73</sup> Comments received at the Samaggi Conference 7-8 February 2009, University of Cambridge, at which the researcher presented on the topic 'Evaluating Healthcare in Rural Thailand-Using a 'Wellbeing Focused Evaluation' (WFE) framework'.

Thailand is still not fully stable. Since 2006 when a military coup took place many populist policies from the TRT, including the '30 baht' or UC scheme, which was replaced by the free healthcare scheme, were altered. Despite the fact that Thaksin was overthrown by the new government and many of his policies were changed, in practice the UC scheme is still working and has even been developed further by later governments. The present government has announced that the Primary Care Units (PCUs), which are used by villagers as a first point of call in accessing healthcare, need to be improved to the standard of Centres for Community Healthcare, including physicians, nurses and healthcare workers. The new government has allocated a huge budget, more than one thousand million baht (equivalent to approximately 166 million pounds or 250 million dollars), to developing the quality and standard of the PCUs throughout the country in 2009 (MoPH, 2009). These continuous changes are part of the transformation of Thailand. The UC scheme is one of the means which the government is using to address people's needs.

This thesis proposed using WFE for healthcare evaluation and by using this approach it has found that the UC scheme has created better conditions for most Thai citizens to pursue greater levels of wellbeing. Therefore, WFE as an analytical as well as explanatory model, could be a useful supplement to conventional UC evaluations, whether in constrained and highly regulated contexts, such as villages in other parts of Thailand, or in other groups with different contexts, or in other developing countries which have introduced healthcare policies for the wellbeing of their citizens.

By providing appropriate measures, this thesis hopes to instigate the beginning of an improvement in the healthcare system towards the development of a 'healthcare system for wellbeing'. A healthcare system for wellbeing in this context entails the establishment of health services that are aimed at improving health proactively and holistically, moving away from a primarily curative service that engages with people only when they are taken ill. This view supports a new dimension for understanding health which covers a broader concept. Hopefully, WFE could also be applied to other forms of social policy, particularly concerning the impact of policy on people's wellbeing.

# Appendices

## Appendix 1

### Benefit Package of Universal Coverage

#### Curative Care and Rehabilitation

##### A. Benefit Package included

1. Curative care and General Rehabilitation
  - 1.1 Examination, diagnosis, curative care, medical rehabilitation and alternative medicine accredited by the medical Registration Committee until the end of therapy.
  - 1.2 Delivery for living children, not exceeding 2 times
  - 1.3 Tooth extraction, occlusion, and cleaning, plastic based denture, pulpotomy, as well as obturator.
  - 1.4 Regular food and room
  - 1.5 Medicines and medical supplies pursuant to National List of Essential Drug.
  - 1.6 Transfer arrangement between health facilities.
2. High Cost Care as prescribed by the committee
3. Accident and Emergency

In the event of accident and emergency, the beneficiaries can utilise every medical care service nearby the place where the injury occurred all over the country within 72 hours. After 72 hours that the injury occurred, health facilities as prescribed in Gold Card shall be responsible for medical care cost.

##### B. Benefit Package does not cover the following medical care service

1. Medical care service for which the budget has been specifically earmarked
  - 1.1 Mental health patient who has been an inpatient exceeding 15 days
  - 1.2 Drug addict therapy and rehabilitation pursuant to Narcotics Laws.
  - 1.3 The injury from car accident under Third Party Liability for Vehicle Accident Laws
2. Medical care service outside primarily necessary cares
  - 2.1 Infertility assisted reproduction
  - 2.2 In vitro fertilisation
  - 2.3 Sexual transplantation
  - 2.4 Any performance for beauty without medical sign
  - 2.5 Any Examination, diagnosis, and therapy outside necessity and medical sign

### 3. Other services

3.1 The same diseases needing therapy as an important exceeding 180 days, except intervening condition or medical sign

3.2 Curative care during research and experiment

3.3 Peritoneal Dialysis and Hemo-dialysis for chronic renal failure

3.4 Anti-HIV immunity, except that of preventing the disease communication from mother to child

3.5 Organ Transplant

### **Promotion and preventative cares-disease control**

2.1 There shall be personal health record for ongoing health is of each person

2.2 Examination and overseeing for health promotion of maternity

2.3 Taking of health, growth development, and nourishing condition of children as well as providing disease immunity pursuant to Immunity Planning of the Country

2.4 Health examination for people and vulnerable groups

2.5 Anti-HIV immunity in order to prevent the disease communicating from mother to her child

2.6 Family planning

2.7 Home visit and home healthcare

2.8 Providing health education to medical care service obtainer, for both person and family

2.9 Counselling and encouraging people to take part in health promotion

2.10 Promote and prevent cares for oral health as follow:-Oral health examination

-Dental health counselling

- Fluoride providing to tooth-decayed vulnerable group such as children, elderly, skull. And throat redio-dagnosis patient

- Pit Fissure (for not exceed 15 years old person)

### Conditions of claim and payment

1. Health facility, main contractor, directly brings its claim to Health Card Fund

2. If there any extra medical care cost, heath facility must not charge any cost other than 30 baht as the fee from patient.

Source: from NHSO's website (cited in Wichaikhun 2004:178)



## Appendix 2

### Questionnaire Interview

Does the Universal Health Care Insurance generate the wellbeing of women and men in rural Thailand?

**Note** The interviewer read the following statement of confidentiality to respondents: All information gathered from the interview is confidential and will be used only for this research. The identity of the respondents or households will not be revealed to anyone. Nobody will be able to identify you or use the information against you.

To the interviewer: The above statement of confidentiality is to be read to all respondents, and when the respondent has agreed to participate in the interview, please tick the box. ☐

Name of the respondent .....	Surname .....
Address no .....	village .....sub-district ..... District .....
Province .....	
Date of interview .....	

#### Part 1 General information

1. Sex
  1. Male
  2. Female
2. Age ..... years
3. Marital status
  1. Single
  2. Married/living together
  3. Widow
  4. Divorced
  5. Separated
  6. Other (please specify).....
4. Highest education
  1. No schooling
  2. Primary school
  3. Early secondary school or equivalent
  4. Early vocational certificate/higher secondary school
  5. Higher vocational certificate / diploma or equivalent
  6. Bachelor's degree
  7. Graduate
  8. Other (please specify).....
5. Occupation (According to respondent's own opinion and can be more than one choice)  
Main occupation .....  
Minor occupation .....
6. Land rights, ownership and living arrangements of the household
  1. Households that **do** own land See below:

1. Owning land but not using it (amount) ..... rai/nhaan
  2. Residence (amount)..... rai/nhaan
  3. Farming (amount)..... rai/nhaan
  4. To let (amount) ..... rai/nhaan
  5. To let by sharing the profit of their farm products (amount) .....  
rai/nhaan
  6. Exchanging it with others for temporary use (amount) ... rai/nhaan
  7. Lending it to others (amount) ..... rai/nhaan
  8. Other (please specify) ..... (amount) ..... rai/nhaan
2. Households that **do not** own land      See below:
1. Not using / not renting
  2. Renting (amount)..... rai/nhaan
  3. Renting by sharing the profit of their farm products (amount) .....  
rai/nhaan
  4. Borrowing it (amount) ..... rai/nhaan
  5. Other (please specify) (amount) ..... rai/nhaan

7. Which were the main sources of your household's income in the last year?  
(Please specify by month, year or whichever is suitable)

Income Categories	Who from (Individual or household)	Amount ( Baht)	Duration (How many months)	Total ( Year)
1. Selling Produce				
2. Salary				
3. Farm Letting				
4. Charity organisations				
5. Borrowing				
6. Remittances				
7. Business / commercial				
8. Wages				
9. Other (please specify) .....				

The household's total income last year was (amount).....Baht

8. What was the main expenditure of your household in the last year?

Expenditure Categories	Amount ( Baht)	Who Paid	Who For
<u>Main Expenditure in each month</u> (Monthly Payment)			
10.1 Food			
10.2 Goods Consumption			
10.3 Electricity/water utilities			
10.4 Healthcare / Medicine			
10.5 Credit Payments (amount of each instalment)			
10.6 Payment for transportation			
10.7 Payment for traditional or social events such as a temple or village festival, marriage, priesthood etc			
10.8 Lottery			
10.9 Other (Please specify).....			
10.10 Payment for Education (fee, stationeries etc)			
<u>Payment for Agricultural Activity (Yearly Payment)</u>			
10.11 Fertiliser			
10.12 Pesticides			
10.13 Hired labour			
10.14 Hired pushcart (small tractor used for ploughing the rice fields) / Fuel			
10.15 Hired rice mill car			
10.16 other (please specify) .....			

The household's total expenditure per year was (amount).....Baht

9. Is your household in any debt?

1. None (Pass to question no 14)

2. Yes

10. Debt Situation

What source does the debt come from?	Debt objective	Amount ( Baht)	Interest	When did the debt start?	Any commitments
1. Agriculture and agricultural cooperatives Bank (state Bank) 2. Commercial Banks 3. Cooperation 4. Village fund 5. Village Bank 6. Local Capitalists 7. Relatives /Neighbours 8. Other (please specify) .....					

11. Do you have a bank account?

1. None

2. Yes (amount) .....Baht

12. Do any members of your household have a bank account?

1. None  
amount)

2. Yes (Please specify who has and

Who	Amount (Baht)
1. Father/ Husband	
2. Mother/ Wife	
3. Grandfather	
4. Grandmother	
5. Son, name.....	
6. Daughter, name .....	
7. Daughter in law	
8. Son in law	
9. Other (please specify) .....	

13. Do you hold any government position at the moment?

1. None

2. Yes ( Please tick the relevant answer/answers)

1. Village Committee

2. Village Health Volunteer

3. Sub-district Head

4. Village head

5. Sub-district committee

6. Other (please specify) .....

14. Which healthcare card do you have?

1. Gold card (pay 30 Baht)

2. Gold card (Free)

Remark: Gold card is named as most villagers use this instead of the universal healthcare insurance card.

## Part 2 General Ideas on the Concept of Wellbeing

15. Can you please tell me about what the word **wellbeing** means to you?

.....  
.....

16. In general what are the **indicators** of people's wellbeing ‘?

.....  
.....  
.....

17. Please tell me about **your wellbeing** at the moment?

1. Good, Please give reasons and your indicators

(Pass to question no. 21)

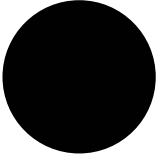
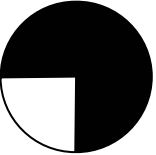
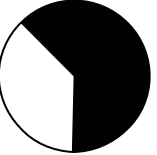
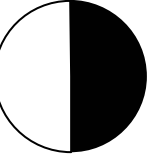
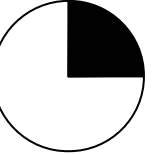
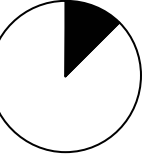
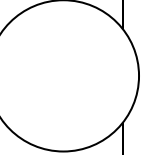
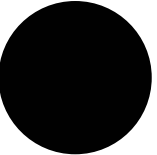
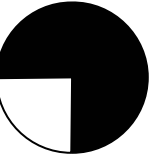
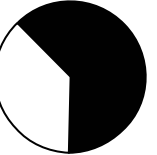
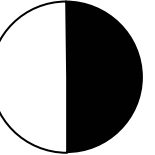
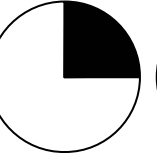
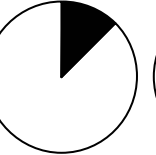
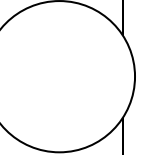
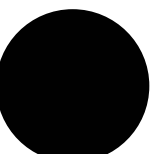


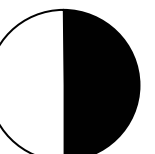
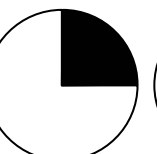
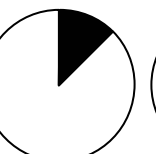
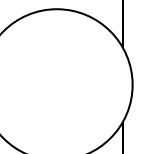
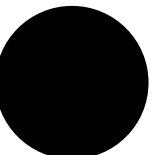
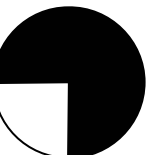
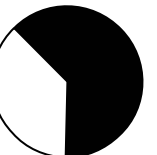
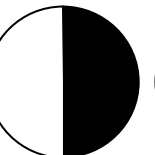
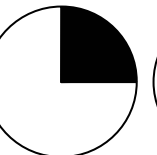
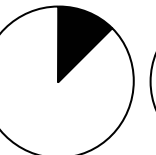
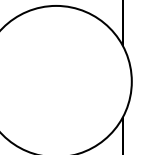
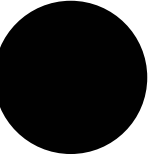
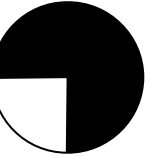
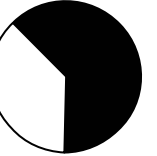
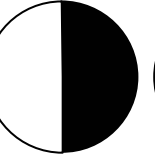
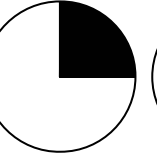
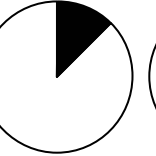
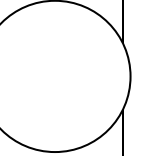
.....  
.....  
.....

2. Moderate (Please give the reason)

.....  
.....  
.....

3. Not good (Please give the reason)

.....  
.....  
.....

18. What are the five most important things that affect your satisfaction?	Level of satisfaction at the moment							Score/Value (Total score must not exceed 10)
								
								
								
								
								

19. If your answer was not good, what you are going to do to better your wellbeing?

.....  
.....  
.....

20. What are the things that will make your wellbeing better in the near future?

.....  
.....  
.....

21. Compared to other neighbors in the community, would you describe your wellbeing as:

1. Better than theirs (Please give the reason)

.....  
.....

2. Same as theirs (Please give the reason)

.....  
.....

3. Not as good as theirs (Please give the reason)

.....  
.....

4. No answer/ Don't know (Please give the reason)

.....  
.....

22. Please describe your **household's wellbeing** at the moment

1. Good (please give the reason and your indicators for them and pass to question no 26)

.....  
.....  
.....

2. Moderate (Please give the reason)

.....  
.....  
.....

3. Not good (Please give the reason)

.....  
.....  
.....

23. If your answer was no, what you are going to do to better your household's wellbeing?

.....  
.....  
.....

24. What are things that will make your household's wellbeing better in the near future?

.....  
.....  
.....



### Part 3) Health and wellbeing

25. Do you think are there any links between health and wellbeing? In what ways?

1. Link (please give the reason)

.....  
.....  
.....  
.....

2. No link (please give the reason)

.....  
.....  
.....  
.....

26. How is **your health** at the moment?

1. Good

2. Moderate

3. Not good

(Please give the reason).....

27. In the last year, have you ever been ill?

1. Yes (Please answer questions in table)

2. No (Pass to question no 28)

1. What kind of illness?	2..Month illness started	3. How many days were you ill?	4. .How many days did you stop working for?	5. How were you cured?	6. Where did you go?	7. Who took you to get the cure?	8. How did you go to get the cure?	9. Have you used the gold card?	10. What was the cost for curing the illness?	11. Other payments please specify
1										
2										
3										
4										
5										

Choices for answer questions above

<b>2. Month</b> 01 January 02 February 03 March . . . 12 December	<b>5. How you cured it?</b> (Write the relevant answer by order) 1. Buy medicine 2. Go to Clinic 3. Go to primary care unit 4. Go to hospital 5. Stay in hospital 6.Traditional care 7. Other please specify	<b>6. Where did you go?</b> (Write the relevant answer by order) 1. Primary care unit 2. Hospital (name)..... 3. Clinic (name) ..... 4. Home 5. Other please specify.....	<b>9. Have you used the gold card?</b> 1. Yes 2. No
--	--	---	---

28. In general, do you have insomnia?
1. Yes
  2. No (Pass to question number 32)
29. What caused you to have this insomnia problem?
- .....
- .....
- .....
30. How did/do you solve the problem?
- .....
- .....
- .....
31. Compared to people who are the same age as you in the community, would you describe your health as:
1. Better than theirs (Please give the reason)
  - .....
  2. Same as theirs (Please give the reason)
  - .....
  3. Not as good as theirs (Please give the reason)
  - .....
  4. No answer/ don't know (Please give the reason)
  - .....
32. In general, would you describe your **household's health** as:
1. Good
  2. Moderate
  3. Not good (Please give the reason).....
33. How many household members are living with you at the moment?.....
34. Can you please tell me about all members of your household and their health situation during the last year?

1. Name – Surname	2. Age	3. Relationship to household head	4. Illness in the last year?	5. What kind of illness was it?	6. Duration of illness?	7. What kind of healthcare did they have?	8. How was it cured?	9. Where was it cured?	10 Who took the patient to get the cure?	11. How did they go to get a cure?	12. Cost for curing the illness?	13. Other payment please specify

Choices for answer questions above

<p>4. Illness in the last year?</p> <p>1. Yes</p> <p>2. None</p>	<p>6. Duration of illness?</p> <p>1. Less than a week</p> <p>2. About a week</p> <p>3. More than a week</p> <p>4. About a month</p> <p>5. More than a month</p>	<p>7. Healthcare options</p> <p>1. Pay themselves (no insurance)</p> <p>2. Social security</p> <p>3. Civil servants/ Privatised public utilities</p> <p>4. Gold Card (pay 30 bath)</p> <p>5. Gold Card (free)</p> <p>6. Insurance Company</p> <p>7. Other please specify</p>	<p>8. How was it cured?</p> <p>(Write the relevant answer by order)</p> <p>1. Buy medicine</p> <p>2. Go to Clinic</p> <p>3. Go to primary care unit</p> <p>4. Go to hospital</p> <p>5. Stay in hospital</p> <p>6. Traditional care</p> <p>7. Other please specify</p> <p>.....</p>	<p>9 Where was it cured?</p> <p>(Write the relevant answer by order)</p> <p>1. Primary care unit</p> <p>2. Hospital</p> <p>(name).....</p> <p>3. Clinic (name) .....</p> <p>4. Home</p> <p>5. Other please specify</p> <p>.....</p> <p>.....</p>
--	---	--	--	--

35.If any members of your household were ill, who looked after them?

- |                        |                                |
|------------------------|--------------------------------|
| 1. Father/ Husband     | 5. Daughter in law             |
| 2. Mother/ Wife        | 6. Son in law                  |
| 3. Son, name.....      | 7. Other (please specify)..... |
| 4. Daughter, name..... |                                |

36. If any members of your household were ill, who would tell them or make the decision for them to go to see a doctor?

- |                        |                                |
|------------------------|--------------------------------|
| 1. The patient         | 5. Son ,name.....              |
| 2. Mother/ Wife        | 6. Daughter in law             |
| 3. Father/ Husband     | 7. Son in law                  |
| 4. Daughter, name..... | 8. Other (please specify)..... |

**Part 4) Actual experience of using the gold card**

37. Have you ever heard about the gold card?

1. Yes                      2. No (Pass to question no 40)

38. If yes, where from? (Please tick the relevant answer/s)

1. Neighbours    2. Healthcare volunteers                      3. Village head  
4. Radio                      5. T.V                      6. Other please specify .....

39. Have you ever used a gold card?

1. Yes  
2. No Please give the reason

(Pass to question no 42 and no need to answer questions in Part 6)

- 1.....  
2.....  
3.....

40. How did you feel when you were using the gold card?

1. Impressed (what is it?)  
.....  
2. Not impressed (what is it?)  
.....  
3. So So

41. Have you ever been ill and did not use the gold card?

1. Yes (Please give reason)  
.....  
2. No

42. If the answer was 'no' to question 40, Would you start using the card if the system was improved?

1. Yes  
2. No (Please give reason)  
.....

43. Will you use the gold card next time you are ill?

1. Yes (Please give reason)  
.....  
2. No (where are you going to go?)  
.....

**Part 5) Knowledge about the gold card**

Please tick the relevant columns

<b>Question</b>	<b>Yes</b>	<b>No</b>	<b>Do not know</b>
44. The gold card can be use for curing/ treating all diseases			
45. All Thai citizens can have the gold card			
46. In the case of an accident, the gold card can not be used			
47. The gold card can be used for an annual health check			
48. The gold card can be used for a cancer check			
49. The gold card can not be used for curing heart disease			
50. The gold card can not be used for curing diabetes			
51. The gold card can be used for curing and recovering of drug- patients			
52. The gold card can be used for optical or eyeglass cases			
53. The gold card can be used for any heath care settings			
54. The gold card can be used for inpatients who have to stay in hospital without limited time			
55. The gold card can be used for contraceptive injections			
56. The gold card can be used for giving child birth			
57. If you do not bring the gold card when you want to see a doctor, you have to pay for care and there are no exceptions			
58. In the case of you being sick, you must go to see a doctor at the first health care setting in which you have registered.			

# Part 6) Satisfaction on using the gold card

Please tick in the columns for your answers

	Level of satisfaction				
	Very satisfied	Satisfied	So.So	Unsatisfied	Very Unsatisfied
59. Time consumed while you were waiting for services after submitting the gold card					
60. Time consumed while you were being redirected to another department?					
61. Consultation about services from the authorities					
62. There were sufficient doctors in every specific disease					
63. There are sufficient authorities					
64. You were treated by same doctor, if being sick with the same disease					
65. If your treatments were continuing were you satisfied with the clarity of the appointment card					
66. You were treated by the authorities who are interested in giving a good service					
67. You were treated by authorities who are eager to help when you had problems when you were using their service-					
68. The authorities had a good temperament					
69. The quality of services were as good as the other health care card holders (Official government and social security)					
70. The quality of the cures were good and the disease was decreased or permanently cured					
71. The quality of services were as good as when the patients pay for care					
72. Service charge is suitable					
73. In general, how would you say the quality of service under the UC scheme is today?					

74. In the last 12 months, what was the amount of money (approximately) that your household spent on healthcare?.....

75. What happened to the level of your household expenditure after using the gold card?  
Did it:
1. Increase
  2. Decrease
  3. Same as before
  4. No answer/ don't know
76. Before having the gold card, your medical healthcare card was.....
77. Which one are you most satisfied with?
1. The gold card  
Please give the reason  
.....
  2. The ex-card  
Please give the reason  
.....
  3. Same  
Please give the reason  
.....
  4. No answer/ don't know  
Please give the reason  
.....
78. Concerning the level of healthcare after using the gold card which of the following is true? Did your healthcare.....
1. Decrease
  2. Increase
  3. Same as before
  4. No answer/ don't know
79. What do you think about the UC scheme? Are you satisfied with it? (please explain?)
1. Yes  
Please give the reason  
.....
  2. No and it needs to be developed (which parts?)  
Please give the reason .....
  3. No answer/ don't know
80. Would you like to have the gold card in the future?
1. Yes  
Please give the reason .....
  2. No  
Please give the reason  
.....
81. In your opinion, do you agree that the gold card should be used for all Thai citizens and that there should be no other forms of health care insurance?
1. Agree  
Please give the reason .....
  2. Disagree  
Please give the reason .....



## Part 7 general ideas on gender and health

82. Have you any children?

1. Yes      Number of children.....
2. No
3. I am single (Pass to question No. 86 )

83. Have you received family planning?

1. Yes    2. No ( pass to question No. 86 )

84. What methods do you used for family planning?

1. Contraceptive Pills
2. IUD (Intrauterine Device)
3. Contraceptive Injections
4. Female sterilisation
5. Male sterilisation
6. Condoms
7. Others, specify.....

85. How many children would you like to have?

Number of children.....

Please give the reason.....

86. If you can choose, which sex would you prefer for your first child?

1. Male

Please give the reason

.....

2. Female

Please give the reason

.....

3. Any

Please give the reason

.....

87. Please give the order of preference for the sex of your next children and the reasons for these preferences.

	Male	Female	Reason
Number 2	21	22	
Number 3	31	32	
Number 4	41	42	
Number 5	51	52	
Number			

88. If you can have only one child, which sex would you prefer?

1. Male

Please give the reason

.....

2. Female

Please give the reason

.....

3. Any

Please give the reason

.....

89. Do you think that males or females in general get sick more easily?

1. Male

Please give the reason

.....

2. Female

Please give the reason

.....

3. Any

Please give the reason

.....

90. In general do you think males and females illnesses are from the same disease?

1. Same

Please give the reason .....

2. Different

Please give the reason .....

91. In general do you think that males or females take better care of their health?

1. Male

Please give the reason

.....

2. Female

Please give the reason

.....

92. In general do you think that males or females go to see a doctor more often?

1. Male

Please give the reason

.....

2. Female

Please give the reason

.....

**Thank you**

## Appendix 3-1

### Interview Guideline for Focus Group I (Villagers) Discussion

1. What are your conceptions of wellbeing/ good life/ better life?  
Why do you think in this way?
2. Are there different conceptions of wellbeing between women and men?  
Why do you think this way?
3. What do you know about the 30-baht health care project?  
When did it emerge?  
Who can use it?  
How can you use it?
4. Are you able to access the 30-baht health care project?  
If so, what are your actual experiences of accessing the project?  
If not, what are the problems?
5. Are there any differences in accessing the project between women and men?  
Why?
6. What are your opinions about the project and how satisfied are you with it?
7. What do you need for your life?
8. Are there any differences in the needs of women and men?  
Why?
9. What do you need from the healthcare project?
10. Does the project suit your need?  
Why?
11. From your experience of using this programme, does it create any inequality?  
Why?
12. Are there differing impacts from the 30- bath health care project on different villages?
13. To what extent does the health care scheme promote your wellbeing?  
In what ways?

## **Appendix 3-2**

### **Interview Guideline for Group II (Health Administrators)**

1. What are your conceptions of wellbeing/ good life/ better life?  
Why do you think in this way?
2. Are there any differentiation conceptions of wellbeing between women and men?  
Why do you think this way?
3. What do you know about the 30-baht health care project?  
When it emerges?  
Who can use it?  
How can you use it?
4. What are your opinions about the project?
5. Are there any problems with this project? If so, what are they?
6. Are there differing impacts from the 30- bath health care project on different villages?
  7. To what extent does the health care scheme promote Thai people (women and men) wellbeing? In what ways?

## Appendix 4

### Semi-structure interview guideline for focus group on health and gender

1. What is your first thought if we talk about “Women”?
2. What is your first thought if we talk about “Men”?
3. How do you teach your children to be a woman?
4. How do you teach your children to be a man?
5. How do you define the meaning of healthy people?
  - 5.1 Healthy children? (girls, boys)
  - 5.2 Healthy teenagers? (girls, boys)
  - 5.3 Healthy adult? (women, men)
  - 5.4 Healthy elderly? (women, men)
6. In your opinion, what are the differences between female and male in terms of illness?
  - 6.1 What are the main illnesses for girl children?
  - 6.2 What are the main illnesses for boy children?
  - 6.3 What are the main illnesses for girl teenagers?
  - 6.4 What are the main illnesses for boy teenagers?
  - 6.5 What are the main illnesses for women?
  - 6.6 What are the main illnesses for men?
  - 6.7 What are the main illnesses for elderly women?
  - 6.8 What are the main illnesses for elderly men?
7. How do you treat yourself when you are sick?
  - 7.1 Self treatment
  - 7.2 Seeing a doctor and self treatment
  - 7.3 Seeing a doctor

## Appendix 5

### Semi-Structure Interview for second fieldwork (In-depth Interview)

1. What are your actual experiences of using the gold card?
  - How did you get access to the card?
  - Have you ever used it, and where?
2. What are your opinions about it?
  - What have you found good and bad about using the card?
3. Please describe about the level of your healthcare (both level of access to healthcare and quality of healthcare) after using the gold card?
  - Compared with before you had the card, do you use healthcare more or less?
  - Do you use other forms of healthcare services? Has this changed?
4. Are there any problems with using the card? (For example, long waiting time, transportation etc.?)
5. Do you feel that you receive a better or worse service? Why?
6. When using the gold card do you feel that you receiving poorer quality (cheaper) medicine and is there any evidence for this? (e.g. before you were prescribed medicine A for this condition, then you were changed to medicine B without a clinical reason)
7. When compared the old card and the new card which one are you most satisfied with? Why?
8. What do you like to change the most when using the gold card?
9. Would you like to have the gold card in the future? Why?
10. Have other people in your family and community used a gold card? Do you think that their experiences were similar to yours? How were they similar or different?

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